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ABSTRACT

The Healthy Tomorrows Partnership for Children Program (HTPCP) is was developed to support special projects demonstrating how states, local agencies, organizations, and communities can work together to improve health of mothers and children. The HTPCP supports a coalition that includes the federal and state governments, professional organizations, foundations, corporate leaders, and families. The HTPCP grant projects described in this document encourage community-based approaches, strengthening the ability of communities to build public-private preventive health strategies. For each of the 52 programs described the problem addressed by the program is given, along with the goals and objectives, methodology, and an evaluation statement. This document details Healthy Tomorrows projects in the following 28 states: (1) Alaska; (2) California; (3) Colorado; (4) Connecticut; (5) District of Columbia; (6) Georgia; (7) Hawaii; (8) Idaho; (9) Illinois; (10) Kansas; (11) Maryland; (12) Massachusetts; (13) Michigan; (14) Minnesota; (15) Mississippi; (16) Missouri; (17) New Hampshire; (18) New Mexico; (19) New York; (20) North Carolina; (21) Ohio; (22) Oregon; (23) Puerto Rico; (24) Rhode Island; (25) South Carolina; (26) Texas; (27) Virginia; and (28) Wisconsin. (BGC)

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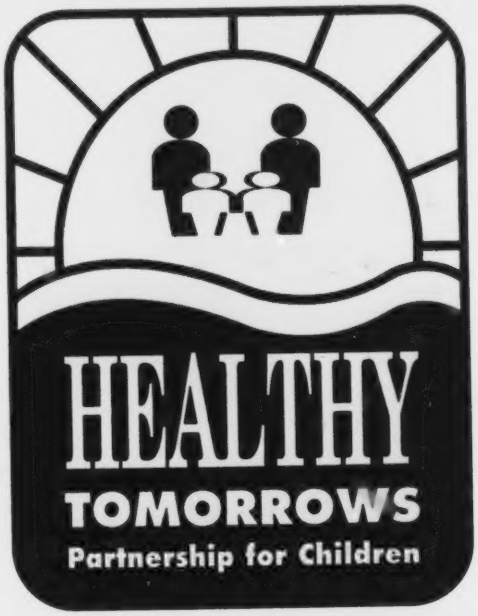
Healthy Tomorrows Partnership for Children

A PROGRAM SPONSORED BY THE MATERNAL AND CHILD HEALTH BUREAU
IN COLLABORATION WITH THE AMERICAN ACADEMY OF PEDIATRICS

Abstracts of Active Projects

FY 1996



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A PROGRAM SPONSORED BY
THE MATERNAL AND CHILD HEALTH BUREAU
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THE AMERICAN ACADEMY OF PEDIATRICS

Abstracts of Active Projects
FY 1996

National Center for Education in Maternal and Child Health
Arlington, VA

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PREFACE

This publication provides information regarding the Healthy Tomorrows Partnership for Children Program (HTPCP), an initiative that began in 1989 to stimulate innovative children's health care efforts designed to prevent disease and disability and promote health and access to health services in local communities across the United States. The HTPCP assists children and their families to achieve their developmental potential through a community-based partnership of pediatric resources and community leadership. This partnership promotes efforts to meet the health and developmental needs of pregnant women, infants, children and adolescents, and children with special health needs and their families.

The HTPCP is a collaborative venture between the American Academy of Pediatrics (AAP) and the Maternal and Child Health Bureau (MCHB), and is part of the Maternal and Child Health Improvement Projects (MCHIP) grant program authorized under Title V of the Social Security Act. The initiative utilizes AAP's network of health professionals, including 59 State chapters and 48,000 child health experts across the United States.

The HTPCP grant program was developed to support special projects that demonstrate how States, local agencies, organizations, and communities can work together to improve the health status of mothers and children. Specifically, the program supports the development of community-based initiatives that: (1) Plan and implement innovative and cost-effective approaches for focusing resources to promote community-defined preventive child health and developmental objectives for vulnerable children and their families (especially those with limited access to quality health services); (2) foster/promote cooperation among community organizations, agencies, individuals, and families; and (3) build community and statewide partnerships between families and professionals in health, education, social services, government, and business in order to achieve self-sustaining programs to assure healthy children and families.

The projects supported by the HTPCP and detailed in this monograph build upon and further encourage community-based approaches that have successfully demonstrated the willingness and the capacity to establish unusual, imaginative, and targeted health initiatives for children and their families. These projects also strengthen the capability of communities to build effective public-private preventive health strategies. The HTPCP brings together local communities to form a unique coalition that includes the Federal and State governments, professional organizations, foundations, corporate leaders, and families. By collaborating and sharing their knowledge and expertise, this coalition for children creates a critical set of resources and a commitment sufficient to establish a framework for mutual problem solving. By combining public and private resources, the coalition achieves a lasting effect upon the health care of America's children by enabling communities to utilize existing resources in the most effective manner possible.

MCHB supports 52 HTPCP projects at a commitment of $19 million over the 11-year period of the initiative. The 52 HTPCP projects described in this document represent a small sample of the more than 900 active projects that MCHB supports in all areas of maternal and child health. It is hoped that the wisdom gained from the projects supported by the HTPCP will be translated for the purpose of enabling the development of prevention programs, compassionate care, and societal reforms that will enhance and protect the health of mothers and children throughout our Nation.

New Beginnings
Southcentral Foundation
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MCHIP
MCJ-028030
10/01/94–09/30/99
Project Director:
David ThunderEagle

PROBLEM: Alaska Natives and American Indians in the Anchorage area make up less than 10 percent of the total population. Statistics from the State of Alaska Division of Family and Youth Services show that Alaska Natives and American Indians consistently make up 33 to 40 percent of the caseload involved with child abuse and neglect.

Phase I of an Indian Health Service (IHS) study on child abuse and neglect being conducted by the National Indian Justice Center (NIJC) has provided the first national profile of Alaska Native and American Indian child maltreatment. The study notes that child abuse and neglect is a persistent problem in Alaska Native and American Indian communities that is not being adequately addressed. Preliminary results of case statistical analysis found that 70 percent of offenders were parents and that almost 80 percent of all cases occurred in the child's home. This indicates a greater need to focus on child abuse and neglect as a family problem in Alaska Native and American Indian communities. Cases of neglect constituted the greatest proportion of reported cases (48.9 percent). Cases of sexual abuse (28.1 percent) and physical abuse (20.8 percent) constituted most of the remainder of the reports. Substance abuse was a factor in 70 percent of cases in which such data were collected. Victims ranged in age from 0 to 18, with a disproportionate number of victims (39.5 percent) less than 5 years old and a substantial number (9.5 percent) under age 1. Other childhood problems include increasing rates of adolescent pregnancy, high rates of fetal alcohol syndrome, high rates of postneonatal mortality, and school readiness issues. Yet these are problems that can be prevented. NIJC noted in its recent national study that child maltreatment is a persistent family problem that is not being adequately addressed in the Southcentral Foundation service area of Anchorage. The vast majority of offenders are parents, but most current programs do not address family dynamics or the need for offender intervention. Substance abuse is a significant factor in a majority of cases. The mental and social health of Alaska Native families is at serious risk of disintegration. While a variety of victim-oriented intervention programs and agencies exist, such as shelters, foster care, and incarceration of offenders, the scope of the problems can no longer be adequately addressed by intervention alone. The lack of a systematic approach to preventive intervention becomes particularly important in light of studies suggesting that those most in need of services are most likely not to receive them.

GOALS AND OBJECTIVES: The goal of the program is to reduce child abuse and neglect in Alaska Native and American Indian families in the Anchorage area. Year 1 objectives are to:

1. Identify 20 at-risk families;
2. Provide home visits to 20 families to assess needs;
3. Promote positive family functioning within 20 families;
4. Promote healthy child development within 20 families;
5. Link 20 families to a medical home and community services; and
6. By the end of the year, place each of the 20 families within levels 1 through 4 for continued monitoring until the infant is 5 years old. The objective for the end of the 5-year period is to reach approximately 200 families, resulting in a 50-percent reduction of child abuse and neglect in the Anchorage area.

METHODOLOGY: The prevention of child abuse and neglect will be facilitated by a family service worker who will be responsible for coordinating screening of medical records by Southcentral Foundation fetal alcohol screening case managers at Alaska Native Medical Center and referrals to different agencies while monitoring the services provided. Further support for the program will include the IHS child psychiatrist, the Southcentral Foundation prematernal substance abuse and mental health treatment center, and Head Start staff. Home visit family support services will include crisis intervention, emotional support to parents, informal counseling, role modeling of family relationships, communication skills, life coping skills, and linkages to other services.

EVALUATION: The goals and objectives require a 10-percent reduction of known child abuse and neglect within year 1. During the remaining 4 years of this project, the frequency of home visits to the initially identified families will decrease and other families will be identified to meet the objective of targeting an estimated 200 families for a 50-percent reduction of child abuse and neglect over a 5-year period. A management information system will be used to monitor and assess accomplishment of the goals and objectives.

Advocates for Children Project/
Healthy Families Ventura
Pediatric Diagnostic Center Associates
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Ventura, CA 93003
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(805) 385-9133 fax

MCHIP
MCJ-068913
10/01/92-09/30/97
Project Director:
Paul Russell, M.D.
Contact Person:
Kathleen Chamberlin

PROBLEM: Prior to the Advocates for Children Project, no early intervention program existed in Ventura County, CA, to identify high-risk families and prevent child abuse and neglect. This had devastating consequences for thousands of children every year. More than 6,000 families representing more than 12,000 at-risk children were reported to Children's Protective Services last year. Approximately 70 percent of children currently receiving services from the Ventura County Mental Health Department—more than 16,000 emotionally or behaviorally disturbed children—have a history of abuse or neglect. Collaboration among public and private agencies in order to identify the at-risk child before maltreatment occurs has been nonexistent. This lack of a formal early intervention program within the county is a health systems problem that has catastrophic effects on the emotional development of thousands of children every year.

GOALS AND OBJECTIVES: The Advocates for Children Project will reduce child abuse and neglect in a targeted population of families. Specific objectives are to:

1. Develop and implement a formal assessment protocol at the Ventura County Medical Center;
2. Develop and implement a community-based home visitation family support program that will begin immediately following the birth of a child;
3. Improve overall family functioning and reduce the incidence of abuse and neglect in the targeted group of families to less than 5 children out of 100 receiving home visitation services;
4. Improve coordination and collaboration between public and private agencies in order to effectively expand prevention resources in Ventura County;
5. Provide a medical home for high-risk families and their children; and
6. Become an active participant in the statewide child abuse prevention program, Healthy Families California.

METHODOLOGY: Women giving birth at the Ventura County Medical Center will be screened and formally assessed for child abuse risk factors using the Kempe Family Stress Checklist. Families that reside in Oxnard and are identified as high risk will be offered voluntary participation in the Advocates for Children Project. Participation will be randomized. Home visitation family support services will be provided by five part-time family support workers (FSWs) recruited from the community. The FSWs will receive formal training from Child Abuse and Neglect, Inc. (CAAN), the participating private nonprofit child abuse organization, in conjunction with the County Department of Public Health Nursing. Training in the Head Start Home-Based Teaching Model will also be provided by our local Head Start agency, Child Development Resources. Case management is provided by field public health nurses who act as a link between the family and the participating primary health care medical homes. Initially, approximately 50 families will receive weekly visits for a minimum of 3 months. Subsequent home visit frequency will be adjusted according to family needs. Families will be tracked for 5 years.

EVALUATION: Three separate groups will be tracked during the 5-year project: 100 at-risk families receiving home visitation, 100 high-risk families referred to Public Health Nursing and not receiving Advocates for Children home visits, and a low-risk group. Overall family functioning and response to stress will be assessed every 6 months in both the home visitation and control groups using the Public Health Nursing Child Assessment Satellite Training (NCAST) and periodic rescoring of the Kempe Family Stress Checklist. Developmental progress will be evaluated using the Denver Developmental Screening Test (Denver II) biannually. Children's Protective Services reports will be tracked. The low-risk group will be tracked to evaluate the validity of the assessment instrument. A Community Advisory Committee has participated in the development of the program and meets monthly to review progress. A family visit coordinator maintains files on each participating family, meets weekly with each FSW, and reviews specific problems with the project director on a monthly basis. The project director also attends CAAN's Board of Directors meeting and the County Child Abuse Council monthly meeting. Updates are given to the County Children's Coordinating Council.

EXPERIENCE TO DATE: The Advocates for Children Project has formally joined with Healthy Families Ventura and the Helping Us Get Started (HUGS) Program to form the Healthy Families Ventura Cooperative. A total of 115 families have received home visitation services. The program has been implemented in four county sites. Clients living in the Oxnard/Port Hueneme area can access one-stop medical shopping at a center site where Healthy Families Ventura offices, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and obstetric, pediatric, and family planning services are located. Additional outside funding that has been obtained will allow for the expansion of the program. The HUGS outreach to pregnant at-risk women has been implemented in five high-risk areas. The Healthy Families Ventura Cooperative has recently been chosen as a Best Standards and Practices Site by Healthy Families California.

Brighter Tomorrows: International Elementary School Family Center Health Project
Children's Clinic
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Box 1428
Long Beach, CA 90801
(310) 933-0430

MCHIP
MCJ-068904
10/01/92–09/30/97
Project Director:
Elisa Nicholas, M.D., M.S.P.H.

PROBLEM: In order to achieve a brighter tomorrow, children must receive a sound education. To obtain this education, children must receive proper food, clothing, and health care. The staff at International Elementary School (IES), a public school serving low-income children from many cultures in downtown Long Beach, noted that children were unable to learn adequately because of untreated illnesses, behavioral problems, and psychological problems. They invited The Children's Clinic (TCC), a nonprofit community clinic, to develop a program for health services at the school site. Collaborative partners—TCC, IES, the local YMCA, Greater Long Beach Child Guidance Center, the local university, and the Long Beach Department of Health and Human Services—planned the project with input from children, parents, teachers, and community leaders. Baseline interviews and surveys revealed that only 21 percent of the children had been adequately immunized by age 2 and that there was inadequate access to primary health care services, acute care services, mental health services, and physical or recreational activities.

GOAL AND OBJECTIVES: The 5-year project has the following goals:

1. Reduce the risk of disease and disability through improved immunization rates and well-child care;
2. Reduce the risk of preventable disease through improved lifestyle behaviors;
3. Reduce the rate of sequelae from delayed diagnosis and treatment of treatable diseases; and
4. Increase the timeliness of medical and mental health care obtained.

This project will be a model for other schools as a collaborative, culturally sensitive, accessible system of improving health care.

METHODOLOGY: The Brighter Tomorrows project provides onsite health services to students and their siblings in two half-day sessions each week. In order to create a seamless health care system, all children are registered as TCC patients and have easy access to all services on the days the school clinic is closed. Bimonthly immunization clinics are held at the school. Screening and treatment of behavioral and developmental problems are also provided onsite. Physical fitness and drowning prevention are taught at the YMCA. An extensive health education program is being developed, focusing on eight health themes selected by parents and students.

EVALUATION: Project staff track the number of clinic sessions; patients seen; Early and Periodic Screening, Diagnostic and Treatment visits; diagnoses; referrals; immunizations; health care educational activities; parent meetings; psychosocial evaluations and treatments; and physical fitness activities.

Project evaluation includes both process tracking and outcome evaluations. Baseline data are obtained by reviewing the immunization records, parent-completed health history forms, and parental surveys. Health education evaluation occurs through pretests and posttests for each theme. Baseline physical fitness and exercise data are collected at the beginning of the YMCA program and at its completion. A matching grant funds formal evaluation. Evaluation of year 1 will be formative in nature, followed by summative evaluation. A control group is being sought.

EXPERIENCE TO DATE: Provision of onsite health care began in February 1993, with an open house attended by over 300 parents and guests, including the school superintendent, the mayor, and city council members. As of June 27, 1995, 1,744 patients had been seen at the school site during clinic sessions. Nine children required hospitalization and 105 were referred for dental and specialty care. Fourteen immunization clinics occurred.

After-hours phone access to medical staff and inpatient care, parental health care, and family planning were provided. Educational packages on first aid, drug abuse prevention, safety, immunization, and care of the sick child were developed; the packages were reviewed and critiqued by evaluators and teachers, with interactive teaching sessions held for parents and facilitated by Latino and Cambodian community workers. Classroom teaching and homework regarding these themes occurred, and students produced videotapes for each theme. Educational materials were distributed to the parents of all 700 students. Yearly health fairs have been held, with over 800 parents and children attending. An asthma support group and CPR training were initiated at the parents' request.

Mental health services began in March 1993, with weekly consultations with teachers and staff and evaluation and treatment of students needing help. The physical fitness component, including drowning prevention, occurs year round. A total of 379 children have received drowning prevention lessons or physical fitness education. Materials produced include handouts on the Brighter Tomorrows project and various health themes, with videotapes for each theme. These handouts, produced in English, Spanish, and Khmer, have been distributed nationally and locally.

East County Healthy Tomorrows Partnership for Children Project
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MCHIP
MCJ-068903
10/01/92–09/30/97
Project Director:
Bronwen Anders, M.D.

PROBLEM: The eastern part of San Diego County has a large population of low-income families with limited access to health care. A single community health center, the East County Community Clinic, provides the only pediatric program with a sliding-fee scale for services and is one of the few centers serving Medi-Cal and Child Health and Disability Program patients. Health problems and risk behaviors in the population include higher infant mortality rates for Latinos and no-care babies than occur in the general population in the region; poor compliance with family planning and preventive health protocols; low breastfeeding rates; a high number of drug-exposed infants; a long delay from birth to initial medical visit; a low immunization rate; a high tuberculosis conversion rate; lack of education regarding appropriate use of preventive and primary care services; and inappropriate use of emergency room facilities.

GOALS AND OBJECTIVES: The overall goal of this project is to improve health outcomes for a culturally diverse, indigent, underserved population. In this project period the following health status improvement goals will be stressed:

1. Improve immunization status by immunizing 100 percent of the children who receive group well-child care from the El Cajon clinic.
2. Improve parenting skills of participants by:
    a. Providing childhood safety education to 100 percent of the mothers presenting their children for group well-child care;
    b. Educating 100 percent of the mothers in the group well-child program about the appropriate method of taking their infant's temperature and having 90 percent of the mothers understand what temperature indicates a fever; and
    c. Educating 100 percent of the mothers enrolled in the group well-child program about the appropriate use of the emergency room.
3. Improve breastfeeding rates by promoting breastfeeding among mothers involved in the program so that 90 percent of the mothers breastfeed for an additional 2 to 3 months and 50 percent of the mothers breastfeed for an additional 9 to 12 months.

METHODOLOGY: Groups of four to six mother-infant (birth to 12 months) pairs meet for 75- to 90-minute sessions at standard well-child intervals (1, 2, 4, 6, 9, 12, and 18 months). The groups will be facilitated by a pediatrician and a bicultural health care educator. The infants' vital signs are obtained at each session. Parents take their own infants' temperatures in the presence of a health care provider. Next, with the parents' assistance, infants are weighed on portable scales, and their growth is plotted on charts.

During the first hour, the American Academy of Pediatrics guidelines for health supervision are used to offer anticipatory guidance and lead open discussions on various topics: Normal development; common problems such as fever, colic, bronchiolitis, and otitis media; and the importance of proper medical management using appropriate health care services. The last 30 minutes of the group session are dedicated to physical exams and immunizations. These exams are performed within the group setting so that parents can appreciate the normal variation of growth and development. At the end of each session, age-appropriate incentives are given (for example, cereal at 4 months, electric outlet covers at 6 months, tippy cups at 9 months, etc.).

EVALUATION: Parents involved in the program will be given surveys at the first, fourth, and seventh visits. Questions asked will include information on the educational topics discussed, and the responses will be evaluated to appraise the participants' understanding of the concepts presented. At the final visit parents will be asked to take their children's temperatures. The mothers will be given a list of temperatures and asked which are considered a fever. The number of emergency room visits made by those involved in the program will be tracked and evaluated for appropriateness. Immunization records for the group will be reviewed for completeness of immunizations. A chart review will be completed at 2, 12, and 18 months to log the numbers of mothers who are still breastfeeding.

EXPERIENCE TO DATE: Since the project's inception there have been 336 well-child group visits. There are 18 groups with 3 to 6 parent-child pairs in each group. The immunization rate for infants participating in the program is 100 percent, and breastfeeding rates have improved.

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Healthy Tomorrows Partnership for Children
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MCHIP
MCJ-068908
10/01/92–09/30/97
Project Director:
Lucinda Hundley, M.A.

PROBLEM: Consider the observations of an American Academy of Pediatrics (AAP) physician examining a group of children. He remarked that he felt as if he were practicing Third World medicine, but he wasn't. He was in Orange County, CA, examining elementary school children in Santa Ana. The 26,000 elementary school children in the Santa Ana Unified School District have been without adequate health care and appropriate resources for followup care. Social service issues are also of great concern. As of 1992, the school district had the highest child abuse referral rate in the county and the second lowest Child Health and Disability Prevention (CHDP) compliance rate in the county (51 percent), with staff continuing to express concerns that parents lack the necessary skills to assume responsibility for their children's physical and emotional well-being. The Santa Ana Unified School District serves a total enrollment of 48,897 students; it is the eighth largest school district in California and the largest in Orange County. It serves the greatest number of minority students of all 32 school districts in Orange County. Of these minority students, 95.1 percent are from ethnically diverse populations, 87 percent are Hispanic (compared with 15 percent statewide), 72 percent are limited English proficient (compared with 22 percent statewide), 40 percent are immigrant, and 71 percent of the elementary students receive free or reduced-price lunches. December 1990 medical examinations of a representative sample of Santa Ana elementary students revealed that 88 percent manifested presenting health problems, some requiring immediate hospitalization. Most students have no health insurance or regular health care. Health care providers reported that health resources are inadequate to meet these needs, made more severe by barriers of language, limited access to facilities, ineligibility for some services, and lack of Medi-Cal coverage.

GOALS AND OBJECTIVES: In order to address the health and social services delivery crisis in Santa Ana, the school district has developed a comprehensive, collaborative effort with its 10 "partners," including Children's Hospital of Orange County, the County Health Care Agency, the local chapter of AAP, and other agencies. Together they have developed goals to target five elementary schools (3,700 students) based on a comprehensive needs assessment, including direction from parents, partner and advisory agencies, and service providers. These goals are to (1) provide preventive, accessible health care for the school district's elementary students; (2) provide school-linked social services; and (3) empower parents as primary caregivers through comprehensive health education. Objectives to meet those goals include:

1. Provision of a mobile medical van staffed with a full-time bilingual pediatrician and bilingual registered nurse (funded through this grant);
2. Provision of appropriate preventive and followup medical care;
3. Provision of a bilingual health insurance counselor/secretary/driver and five full-time school-linked social workers; and
4. Development of a comprehensive parent education program.

METHODOLOGY: Through outstationed staff redirected from the partner agencies, the program provides school-linked health and social services to children whose problems are judged by the school site team to be beyond their expertise. The goal of this effort is to address the needs of approximately 1,000 such children per year. The mobile medical van provides immunizations, well-child physical exams, treatment of minor medical conditions, and appropriate medical referrals for followup care, with emphasis on preventive health care. Dental services are also provided to students. Thirty-six area pediatricians have each committed to two or three pro bono cases per month for followup care, in addition to monthly pro bono dental care by a local comprehensive care provider. Five social workers are assigned to the five targeted schools, providing crisis intervention, small-group and individual counseling, and parent education, referral, and followup as needed. Additional services consist of parent education coordination, utilizing and expanding existing resources for culturally sensitive and language-appropriate parent education programs and leadership/mentor programs. Central to the program design is the concern that these minority families are not accessing needed and critical care; hence the program seeks to make services accessible through a coordinated, school-linked model. This program represents a remarkable commitment of more than $600,000 in redirected, in-kind services.

EVALUATION: Initial program evaluation was conducted in June 1993 and January 1994 using outcomes data collected on an ongoing basis from student and health agency intake and financial records, supplemented by (1) an assessment of quality of care, based on user, provider, and partner interviews; (2) parent focus group interviews and surveys; and (3) an assessment of institutional changes such as school practices, funding streams, and professional health and education linkages, based on interviews with practitioners from both sides of the relationship. Evaluation results indicate a strong approval of the program, providing confirmation that the program is greatly needed, is welcomed by parents, and will produce measurable results in academic achievement and family functioning as well as in general health conditions in children.

EXPERIENCE TO DATE: Now completing its third year, the program exceeded its annual goal of serving 1,000 students by providing medical services to 1,870 students on the medical van, 815 students receiving direct social service interventions, and 377 students referred for followup care due to significant health problems. Over 1,800 parents participated in culturally and language appropriate parent education programs, in each of the five schools, with 96 percent of surveyed families reporting that Healthy Tomorrows had a positive impact on their lives. Three additional partner agencies have joined the program, in addition to six volunteer dentists in the area and a local dental services provider.

San Diego Adolescent Health Care Project: Medical Outreach for High-Risk Teens and Their Families

Logan Heights Family Health Center
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San Diego, CA 92113
(619) 234-8171

MCHIP
MCJ-068918
10/01/93–09/30/98
Project Director:
Joseph Browne, M.D.

PROBLEM: Society in general and the health care system in particular have failed an extremely vulnerable, high-risk, medically underserved, and difficult-to-reach population: Homeless adolescents. An estimated 12,000 adolescents per year have run away from home ("overnight runaways") in San Diego County. Thousands more adolescents and their families are at significant risk for homelessness. Additionally, there are at least 1,115 runaway or "throwaway" homeless youth who have lived on the streets every night for an extended period of time, with little hope of reuniting with their families. Many have been physically or sexually abused, have been abandoned by their caretakers, have come from families of substance abusers, become substance abusers themselves, and engage in behaviors such as "survival sex" that place them at high risk for unplanned pregnancies and sexually transmitted diseases (STDs), including HIV infection. Their living conditions make them highly susceptible to tuberculosis and other communicable diseases. Medical problems go undiagnosed and untreated because of poor access to the health care system. An innovative, community-based approach is needed to bring comprehensive, case-managed primary care to places where homeless, runaway, and near-homeless adolescents gather.

GOALS AND OBJECTIVES: The 5-year project has the following goals:

1. Create a system of comprehensive, case-managed health care for the thousands of throwaway, runaway, and near-homeless adolescents in San Diego, bringing available services to places where adolescents and their families live and congregate;
2. Create a coalition of community agencies and pediatric professionals dedicated to providing services to homeless adolescents;
3. Collect and disseminate project data, including demographics, chronic and acute medical conditions diagnosed, and contagious diseases with significant public health ramifications, such as STDs, HIV, and tuberculosis; and
4. Obtain a detailed risk assessment to monitor clients' knowledge, attitudes, beliefs, and behaviors.

METHODOLOGY: A bilingual (Spanish) health care team—composed of individuals experienced with the special medical and psychosocial problems faced by homeless, runaway, and near-homeless adolescents—provides comprehensive, case-managed health care onsite in places where adolescents live and congregate. The Mobile Health Outreach Team (MHOT) is composed of a pediatrician/project director, a physician assistant, a registered nurse project coordinator/case manager, a medical assistant, and a patient services representative. The team is supported by an evaluation specialist and is closely linked with all health education and promotion programs at the Logan Heights Family Health Center (LHFHC), as well as with outreach and case management staff from the Health Care for the Homeless Project, for which the LHFHC is the lead agency.

EVALUATION: A project advisory committee has been assembled. Working with staff, the committee will evaluate data regularly to assess the impact of the interventions. Their evaluation will be used to modify the program as time goes on. Throughout the course of the project, data will be collected on the number of encounters; diagnoses; and demographics, knowledge, attitudes, beliefs, and behaviors of the patient population.

Statistics collected in years 2 through 5 will be compared to baseline data from year 1. Data will be shared with local and State agencies to promote better planning.

EXPERIENCE TO DATE: Two sites were established during year 1. The Place, an alternative school for homeless and runaway youth in downtown San Diego, is linked with shelters and other youth-serving agencies. Bandini Elementary is an inner-city school where the team, with the school nurse practitioner, provides case-managed care to children of families at risk for homelessness. Patients are linked with the health center, the "medical home." Risk assessment data showing a high level of risk-taking behavior are confirmed by diagnosis data. The risk assessment has been revised to make it simpler, more culturally relevant, and suitable for younger children. Additional funding has been obtained through the Healthy Schools, Healthy Communities program, and a new full-time school-based site is operational, including health education and mental health components. Plans this year call for documentation and replication of the model, computer linkages with the health center, and increased linkages between school nurses and the mobile team.

San Diego County Dental Health Initiative
San Diego Child Health and Disability
Prevention Program
Children, Youth, and Families Health
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San Diego, CA 91910
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MCHIP
MCJ-068005
10/01/95–09/30/2000
Project Director:
Amethyst Cureg, M.D.

PROBLEM: Pediatric dental disease is a significant and growing problem in San Diego County, especially for children from culturally diverse families. According to the American Academy of Pediatrics, Chapter 3, District 9, Community Access to Child Health Committee's 1992 report *Access to Health Care for Children in San Diego County*, 31 percent of children in low-income areas have neither health insurance nor Medi-Cal coverage, and an even larger percentage have no dental coverage. Survey results have shown that 60 percent of low-income children under 5 years of age and 27 percent of children over 5 years of age surveyed did not have a dentist. Unlike many other medical conditions that are self-limiting, untreated oral diseases typically become more serious, more difficult, and more expensive to treat. Adverse health consequences of untreated dental disease include severe pain, inability to chew food, severe systemic infections, psychosocial problems, impaired nutrition, weight loss, disfigurement, and even death. Public-funded programs intended to provide coverage to San Diego County's income-eligible children either have been unable to maintain adequate funding or have not addressed issues related to treatment of urgent dental health needs. Specific problems facing culturally diverse families seeking dental care include the paucity of dentists willing to accept Denti-Cal, the limited number of dentists sensitive to the cultural needs of non-English-speaking families, the lack of dental care for children whose families have no or limited resources to pay, a lack of awareness of the importance of early dental care, and the lack of a system for coordination of dental referrals and care.

GOALS AND OBJECTIVES: The overall project goal is to improve the oral health of children in San Diego County. Health systems improvement goals are to provide:

1. Quality oral health care at no cost to culturally diverse, underserved income-eligible children with urgent dental needs; and
2. Community-based cultural specific approaches to oral health education for families.

Objectives for the first year are to recruit 200 dentists, increase treatment capacity by 300 children, recruit 50 percent of the dental providers able to serve non-English-speaking families, and establish a referral system for treatment of 50 siblings.

The health status improvement goal is to increase the number of children receiving oral care for urgent conditions of dental disease or injury. The objective is to reduce by a minimum of 300 the number of childen experiencing urgent dental care needs.

METHODOLOGY: The project will develop and coordinate a community-based, public-private partnership model to match dentists and pediatric care providers with school-age children from culturally diverse families who need urgent dental care. This care, provided at no cost to the family, will be coordinated by the project coordinator. Eligible children will be referred for care by Child Health and Disability Prevention (CHDP) Program providers; Healthy Start, Head Start, State Preschool, and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) staff; community-based agency staff; and pediatricians and school nurses. Low-cost care for siblings with urgent dental needs will be made available through scholarship funds and special dental payment schedules. Local dentists will be recruited through professional societies and outreach. Special attention will be given to recruitment of providers able to provide culturally sensitive services to diverse families.

A family-oriented education program—which includes parent-to-parent and youth peer training, as well as a training-the-trainer component—on the importance of early and regular dental care will be established and implemented through Healthy Start, Head Start, State Preschool, WIC, community-based agencies, pediatric providers, and other providers. Emphasis will be placed on teaching families preventive care for children's primary teeth.

The San Diego County Dental Health Initiative (DHI) Advisory Committee is composed of professionals, parents, schools, preschools, and culturally sensitive community-based agencies. This committee will support, advise, and review the progress of the initiative in meeting the dental health care needs of families and children.

EVALUATION: Both process and outcome evaluation will be used. The number of eligible children accessing care through DHI referrals will be compiled each program year. Dental provider participation and satisfaction will be documented. Program cost analysis will be conducted to determine cost-effectiveness and efficiency levels. Community agency and family and parental education will be evaluated based upon preventive health knowledge, practices, and behaviors before and after access to education.

Healthy Tomorrows for Denver
Denver Health and Hospitals
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MCHIP
MCJ-088807
10/01/92–09/30/97
Project Director:
Jeffrey M. Brown, M.D., M.P.H.

PROBLEM: In cities across the United States, infants and children with or at risk for developmental delays are falling through the cracks of the existing service delivery system. In Denver, this gap is particularly evident in the pediatric population served by Denver Health and Hospitals (DHH), the heart of the city's public health care system and the primary provider of care to Denver's low-income and culturally diverse neighborhoods. This Federally Qualified Health Center serves approximately 2,000 infants and children with or at risk for developmental delays each year, many of whom are identified at birth. Fully 12.5 percent of the 2,939 infants born to DHH families in 1991 were low birthweight, and only 55.8 percent were classified as normal newborns. Ideally, DHH caregivers would routinely identify and refer these infants and children to Child Find of Denver Public Schools—Denver's single point of entry for families seeking access to early intervention services and supports. However, due to limited DHH caregiver knowledge of P.L. 102-119 (IDEA) and minimal Denver health and education system collaboration, only about 100 infants and children are identified and referred from DHH to Child Find each year. In addition, families that are referred from DHH to Child Find often fail to complete the evaluation process and to access services. Out of 77 children ages 0–5 identified by DHH and referred to Child Find in 1992, only 57 percent completed the Child Find evaluation process. This is largely the result of various motivational, financial, and cultural barriers to care, combined with fragmented service systems, lack of tracking and monitoring systems, and lack of service coordination and outreach. These conditions limit family access to services and supports guaranteed under P.L. 102-119.

GOALS AND OBJECTIVES: The goal of the Healthy Tomorrows for Denver (HTD) project is to increase access of children ages 0–5 with or at risk for developmental delays and their families to Denver early intervention services and supports guaranteed under P.L. 102-119. Specific goals are to:

1. Increase DHH outreach and child identification;
2. Ease and expedite the Child Find process;
3. Promote family use of early intervention services; and
4. Develop a tracking and monitoring system.

Five measurable objectives are proposed to achieve these broad goals.

METHODOLOGY: Two methods are employed by the project, including the institutionalization of DHH referrals to Child Find and service coordination for families referred. All DHH children ages 0–5 identified as having or at risk for developmental delays are referred to HTD for service coordination and referral to Child Find and services. A referral followup system from HTD/Child Find back to the DHH referral source has been established to promote caregiver involvement in the Individualized Family Service Plan (IFSP)/Individualized Education Plan (IEP) and to encourage ongoing referrals. HTD service coordination uses professional and paraprofessional home visitors to assist families in identifying individual strengths and needs, providing support and parent mentoring, identifying evaluation and service options, collaborating with service providers, and coordinating care. Families are followed through the process of child identification, multidisciplinary assessment, IFSP/IEP development, service identification and implementation, and review and evaluation of plans. The average service coordinator caseload is 50 families. The targeted length of time for service coordination is 3 months for families fully involved with the IFSP/IEP, after which they are transitioned back to the DHH caregiver and/or community provider. An estimated total of 850 families will receive service coordination services throughout the life of the project.

EVALUATION: During the fourth quarter of years 2, 3, and 4 of the project, HTD will gather and analyze formative feedback from families, DHH staff, and community providers using focus groups and family and provider satisfaction surveys. The HTD data base will be analyzed and all data evaluated in collaboration with an evaluation consultant and used to refine the project as indicated. The internal management mechanisms used by HTD are the HTD data base and regularly scheduled meetings. The data base collects demographic, diagnostic, treatment, referral process, and system access data on all referred families, assisting Denver's health and education systems in tracking and monitoring family access to and use of services. Regularly scheduled meetings include monthly meetings of the HTD Executive Committee and quarterly meetings of the Advisory Board.

EXPERIENCE TO DATE: The project has successfully served over 600 families to date. Current project activities focus on institutionalizing HTD within DHH through the combination of HTD, medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and the Health Care Program for Children with Special Needs under a potential new DHH Division of Child and Family Health.

Prenatal-to-Pediatric Transition Project

Fair Haven Community Health Clinic, Inc.
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MCHIP
MCJ-098125
10/01/93–09/30/98
Project Director:
Laurel Shader, M.D.

PROBLEM: The Fair Haven Community Health Center (FHCHC) is the sole source of health care in a neighborhood of New Haven, CT, that is isolated from the rest of the city. FHCHC provides primary care to 10,000 patients in 40,000 visits a year. FHCHC's prenatal and pediatric population is 83 percent minority, with 95 percent having incomes below the poverty level. Twenty-five percent of the prenatal women are adolescents and 4 percent are less than 16 years of age.

The City of New Haven has distressingly high rates of infant mortality and low birthweight, a low rate of immunization levels for children at 2 years of age, and increasing rates of substance abuse and HIV infection among pregnant women. Access to culturally sensitive medical, dental, and social service providers is fragmented.

GOALS AND OBJECTIVES: The goals of the Healthy Tomorrows Prenatal-to-Pediatric Transition Project are to increase coordination among health care resources and to provide enhanced health education, highlighting normal infant development, proper nutrition, and preventive pediatric care. The project will achieve these goals by meeting the following objectives:

1. Integrating a prenatal to pediatric transition model similar to those used in the private sector;
2. Providing enhanced prenatal and pediatric education;
3. Ensuring compliance with American Academy of Pediatrics guidelines for well-child care and immunizations;
4. Assisting parents with early detection of developmental abnormalities;
5. Reducing inappropriate emergency room (ER) visits by 15 percent per year for infants; and
6. Facilitating coordination between specialty and primary care providers.

METHODOLOGY: Several approaches were chosen to recruit families for FHCHC's enhanced programs:

1. A transition visit for women pregnant for the first time to meet with a midwife and pediatric clinician at 34 weeks' gestation to discuss relevant medical and social issues;
2. Chil[illegible]h education classes;
3. HIV counseling and testing;
4. A meeting with a nutritionist from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC);
5. Hospital care for all newborns delivered by FHCHC midwives;
6. Improved case management services;
7. Improved compliance with well-baby care and immunizations;
8. An effort to decrease inappropriate use of the emergency room through education; and
9. Parenting classes scheduled to begin in the fall.

EVALUATION: The following key activities of the project have been tracked for up to 9 months:

1. Compliance with and content of the transition visit;
2. Newborn admissions at the Hospital of St. Raphael;
3. Compliance with standards for well-baby visits and immunizations;
4. Contacts with social services; and
5. Use of the emergency rooms at both local hospitals.

Baseline data will be compared against data for the project cohort as the babies reach their first and second birthdays.

Project data should show that reducing perceived and actual barriers to access, providing center-based case management, and improving overall continuity of care improves compliance with standards of pediatric care for infants. Project staff continue to focus efforts on developing baseline data, identifying cultural and language barriers that affect patients' ability to receive or follow through with care, and examining the health systems at FHCHC and linkages (or lack thereof) with providers that affect the staff's ability to coordinate care.

EXPERIENCE TO DATE: Since October 1993, the FHCHC pediatric clinicians have been the physicians of record for all newborns delivered by FHCHC midwives. This policy will continue with adaptations, given the shift in State policy to 24-hour discharge following normal deliveries. All primigravida patients receive transition visits. Emergency room data are tracked on EP16, and we have been designing our initial report, detailing baseline ER usage for our pediatric population. Additional baseline data are being gathered on patients' utilization of health and social services. Distribution of emergency supplies and infant equipment continues. Finally, several pediatric clinicians have spoken at local schools. As we have strengthened our presence in the community, we have received donations of goods and equipment from area businesses.

Accessing a Primary Health Care Home Through Case Management
District of Columbia Department
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Commission of Public Health
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MCHIP
MCJ-118339
10/01/94–09/30/99
Project Director:
E. Elaine Vowels, Ph.D.

PROBLEM: In the District of Columbia, many low-income parents of at-risk and disabled children are not receiving coordinated, comprehensive health care. These children lack a "primary health care home" that provides continuity of care. Many lack financial access to health services; only about 40 percent of children receive appropriately scheduled immunizations, and it is estimated that a similar number are not tested for blood lead levels. Many children do not receive adequate primary care on a regular basis. Health education on preventable conditions and on acute and chronic illnesses is insufficient. Too many have too little knowledge of how to navigate the health and social services delivery system. The specific problems are (1) the systematic problem of access barriers to health care relative to medicaid enrollment and maintenance; (2) the health status problem of the underutilization of primary obstetrics and pediatric health care (physical network); (3) the health status problem of low immunization rates for preventable childhood diseases; and (4) the health status problem of inadequate lead poisoning screening of the District's children.

GOALS AND OBJECTIVES: The major goal of the project is to promote the concept of the primary health care home, wherein every child has one provider who ensures continuity of health care services. This can be accomplished through a collaboration with hospitals, private practices, and individual empowerment relative to primary health care and community-based services. These community outreach goals include in-depth and culturally sensitive health education activities and appropriate assistance in enabling parents to access the medical and social service systems. Specific measurable objectives to be met by October 1999 include:

1. An increase in continuous medicaid coverage for 90 percent of project participants for the duration of the project;
2. An increase in the proportion of children and families who receive recommended primary care services at appropriate intervals to at least 90 percent, in accordance with *Healthy People 2000* goals;
3. An increase of immunization rates for children less than 2 years old to 90 percent, in accordance with *Healthy People 2000* goals; and
4. An increase in lead screening rates to 90 percent for children who are at environmental risk.

METHODOLOGY: The at-risk population will be divided into experimental and control groups comprising 100 children each. Appropriate statistical randomization selection methods will be used to avoid self-selection that may adversely affect the outcome of the study. The experimental group will receive proactive, comprehensive care by identifying, tracking, and providing case management services (family-centered, community-based primary health care case management model) within the primary health care home concept, whereas the control group will continue to receive care currently available. This study is designed as a quasi-prospective random sample control intervention trial. It will be nearer to a factorial trial or survey, where two or more treatments are used singly and in unison so that possible interactions and their effects can be measured. Community members will be involved in the planning process for determining the methods and implementation of this project. The experimental group of children will receive recommended immunizations and an annual blood lead level screening with intensive followup in addition to the regular medical and health care service. The experimental group will be compared with the control group, which will continue to receive current services. The hypothesis is that children and families in the experimental group receiving more intensive care within the primary health care home model will maintain continuity of care as measured by appropriate health indicators such as immunization uptake, annual lead screening, annual number of primary care visits, successful breastfeeding practices, and progress of growth and development. This will improve the accessibility of primary care physicians network and medicaid services in accordance with *Healthy People 2000* goals.

EVALUATION: A comprehensive evaluation of the project will be undertaken using process outcome and impact methodologies. Summative data will be used to assess the overall impact of the project on the targeted populations, on utilization of services, and on case management practices in order to determine the relationship between project objectives and actual outcomes. Participating families will formally evaluate the project's reliability, relevance, and effectiveness through the use of self-sufficiency and parenting empowerment surveys before and after entry into the project. The evaluation plan will track six elements: (1) Eligibility and referral progress, (2) effectiveness of case management intervention, (3) followup data, (4) management of project activities, (5) quality control, and (6) project objectives. Reports will be produced with specific recommendations to aid planners and policymakers in developing programs that will ultimately translate into improved health status for mothers and children in ward 6 and the District of Columbia.

EXPERIENCE TO DATE: During the first year of the project, the following program activities have been developed and implemented:

1. The personnel necessary for project development and implementation have been employed;
2. The project team has established a network of four primary health homes in ward 6;
3. Collaboration with community-based organizations has been established;
4. Training on medicaid utilization and cultural competence has been organized for project staff;
5. Incentives for participants are available;
6. The pilot project began with the use of focus groups; and
7. Matching funds have been secured for year 2.

Making Dreams Possible for Hispanic Teens

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MCHIP
MCJ-118337
10/01/94–09/30/99
Project Director:
Elida Vargas, M.S.

PROBLEM: Adolescent pregnancy and sexually transmitted diseases (STDs) are growing at an alarming rate in the District of Columbia's burgeoning, newly immigrated Hispanic community, reflecting national trends. Between 1986 and 1991, while the adolescent birth rate increased 19 percent among whites and 13 percent among blacks, it rose a dramatic 34 percent among Hispanic adolescents. In general, too-early childbearing exposes an adolescent and her baby to poor pregnancy outcomes such as low birthweight, diminished educational opportunities, and poverty. This is especially true in the District of Columbia, where Hispanic adolescents and their infants lack basic access to prenatal, pediatric, and primary health care services; face a multitude of psychosocial and economic stressors; and experience difficulties in school (a 45-percent high school dropout rate among Hispanics). Once Hispanic adolescents drop out of school, they tend to become isolated from the health and social service system, which places their children at increased risk for vaccine-preventable diseases, developmental delays, child abuse and neglect, and other adverse health outcomes.

GOALS AND OBJECTIVES: The goals of this project are to:

1. Develop a system that links Hispanic adolescents in the community to essential bilingual, community-based services that prevent pregnancies, STDs, and other adverse health outcomes for adolescents; and
2. Provide bilingual, comprehensive, supportive services to 200 hard-to-reach Hispanic pregnant adolescents and their infants enrolled at Mary's Center, with a focus on the prevention of repeated pregnancies and adverse child health outcomes.

Year 1 project objectives are to:

1. Increase from 50 percent to 90 percent the percentage of Hispanic adolescents seeking primary health care services who agree to be screened for STDs during their physical exam;
2. Prevent pregnancies among 85 percent of 180 Hispanic adolescents seeking primary health care services (no baseline, since primary health care services for adolescents started only in November 1993);
3. Reduce the low birthweight rate to no more than 3 percent among the infants born to 40 Hispanic adolescents (baseline: 7 percent over 4 years);
4. Increase from 60 percent to 90 percent the percentage of the 40 Hispanic adolescents and their partners who receive HIV testing and counseling by the second trimester of pregnancy;
5. Increase from 70 percent to 95 percent the percentage of infants born to the 40 Hispanic adolescents who receive timely immunizations;
6. Increase from 60 percent to 90 percent the percentage of infants born to the 40 Hispanic adolescents who are screened for developmental delays and referred to appropriate services; and
7. Reduce the rate of unintended repeated pregnancies to no more than 8 percent among the 40 Hispanic adolescents (baseline: 14 percent over 4 years).

METHODOLOGY: Mary's Center will collaborate with The Latin American Youth Center to provide bilingual, culturally competent, community-based, family-centered, comprehensive services to Hispanic adolescents (ages

13–21) and their young children (ages 0–13) residing in the District of Columbia. A project director and a case manager will assess the needs and knowledge of adolescents, provide them with basic education on STDs and family planning, and enroll them in the Saturday Teen Clinic (STC) for primary health care. The case manager will provide continuous and individualized case management to pregnant adolescents and their infants to increase compliance with services and to facilitate access to educational, vocational training, and other programs that will help them to avoid repeated pregnancies and adverse child health outcomes. In addition to Mary's Center's routine one-stop shopping services, pregnant adolescents and their infants will receive (1) nutrition education; (2) a six-part "Strengthening the Family" series; (3) home visits; (4) developmental screenings and referrals; and (5) parenting training on child development, stimulation, and abuse and neglect. These services will be provided by a health educator, four home visitors, and a child development specialist. Partners and parents will be encouraged to participate in all interventions.

An outreach worker will conduct outreach/education in the community to facilitate access to the STC and Mary's Center's one-stop shopping services. Project staff will also participate in media advocacy and community networking to increase public awareness about health issues and to expand services for Hispanic adolescents and their families.

EVALUATION: Data will be collected from the adolescents, their partners, and their parents at four focal points: At entry, at 6 months, at time of delivery, and at 12 months into the program. These data will provide information about participants' satisfaction with services provided and about increases in access to services, knowledge, and skills. Printouts from a central computer and a review of medical charts will compare outcomes with baseline data. Project monitoring will include weekly meetings and monthly case conferences. Data collection and organization will be conducted by staff, and analysis will be done by the Catholic University School of Social Work.

EXPERIENCE TO DATE: From October 1994 to June 1995, the Making Dreams Possible for Hispanic Teens project has served 189 teens (males and females) through its pregnancy prevention and primary health services program. Outreach to D.C. public schools has reached 284 youths from 3 local high schools and 1 junior high school. Seven Spanish-language radio programs on pregnancy prevention, STDs, prenatal care, and other topics have been hosted by a member of the advisory board. In addition, the Men's Club has worked with 30 partners, who received computer training, GED preparation, and education on prevention of pregnancy and STDs, including HIV/AIDS. Twenty-five pregnant adolescents have received 20 hours of parenting training.

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MCHIP
MCJ-138420
10/01/93–09/30/98
Project Director:
Virginia G. Galvin, M.D., M.P.H.

PROBLEM: Within Cobb County there is limited access to comprehensive primary care for children and youth (0–21 years) who have medicaid or are uninsured. As of January 1994, more than 9,000 children and youth in Cobb County were medicaid eligible, and access to primary care services for them was limited to hospital emergency departments or hours pediatric clinics. A total of 44 pediatricians and 38 family physicians were informally surveyed. From this survey it was found that only 12 physicians accepted medicaid and only 2 took new medicaid patients. Primary care clinics in other parts of metropolitan Atlanta were used for primary care, but lack of transportation makes access to them difficult. Some families were using the Cobb County Human Services Coalition Clinic, a volunteer clinic established to serve some of the health needs of the homeless, for their primary care. Well-child services offered by the Cobb County Board of Health had waits of more than 2 months for appointments. Hospitals and private physicians took emergency referrals, on a rotation basis, for a specific followup visit or a specific hospitalization. After providing initial followup care, the physicians had the option of continuing to provide comprehensive or episodic care or discontinuing care and allowing the child to reenter the "lottery" system of care. Children with chronic illnesses such as asthma and heart disease had no medical home. Because many children seen in the clinics could not afford prescribed medications, definitive therapy was delayed or never followed through on. No agency or provider served as the "gatekeeper" or primary care home. In January 1993, the Cobb Health Futures Alliance (the Alliance) began enrolling children.

GOALS AND OBJECTIVES: The goal of this project is to expand and extend access to the Cobb Health Futures Alliance comprehensive primary care services. To accomplish this goal an additional pediatrician is needed. This addition will allow expansion of clinic hours and 24-hour coverage for the target population. These activities will help the Alliance build capacity in order to provide high-quality single-site primary care.

The objectives are as follows:

1. By October 1994, hire a pediatrician. The pediatrician will be able to provide for more children, extend hours, and increase the ability to enroll children in the Alliance.
2. By December 1994, establish extended afterhours services, which will provide additional coverage for customers.
3. By January 1995, develop and complete protocols to follow for hospital admissions. This would provide nurse-practitioners with procedures to follow when acting in the role of physician extender. A precertification process for hospital admissions will also be developed.
4. By July 1994, complete structure for integration of services through the Alliance (e.g., dental, outreach, mental health).
5. By December 1994, establish baseline measurements of health status indicators for Alliance children, using *Healthy People 2000* as the model.
6. By September 1994, enroll 60 percent of the eligible newborn medicaid population prenatally.
7. By October 1994, conduct three focus groups of parents to discuss customer satisfaction and develop ways to improve services.
8. By October 1998, secure funding for expansion to a permanent site that provides comprehensive primary care for children.

METHODOLOGY: Each Alliance partner brings to the table a specific part of the system and works to coordinate its services with the other partners. Each partner plays a specific role. Parents enroll their children and ensure that they receive important preventive and health maintenance care. The hospital partners provide the majority of the acute episodic care for sick and injured children. The Cobb County Board of Health provides well-child checkups, immunizations, and health education classes for parents. Private sector pediatricians provide a single-site medical home for children with chronic illnesses. Marketing and referrals from partners and school systems inform families of the Alliance.

EVALUATION: The workplan that has been established lists each program objective, strategies for completing the objective, date to complete each strategy, and the staff members responsible for each strategy. Objectives will be added to the workplan as needed. Core staff meet monthly to report progress. All medical records on Alliance children are computerized. Periodic data analysis is conducted on records to monitor progress on process and outcome indicators. Changes in health status indicators will be assessed from these data. Reports on analysis are provided to core staff at monthly meetings. Parents of the Alliance children are partners in the evaluation process. Parents participate in focus groups and are surveyed for customer satisfaction. Changes in hospitalization and emergency room visits will be assessed. The program evaluation includes a model that will be used to assess changes in school absenteeism and performance.

EXPERIENCE TO DATE: The principal stumbling block of the project has been the inability to obtain a second pediatrician. A second pediatrician will be coming on board in July 1995. Even with this delay, 5,000 children have been enrolled in the Alliance since January 1993. The goal was a minimum of 3,000 children within 2 years. Children with chronic conditions are being referred to private physicians, hospital partners, and Children's Medical Services. Collaboration is the key component of the project.

Grady First Steps to Healthy Families

Fulton-DeKalb Hospital Authority
Grady Health System
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Atlanta, GA 30335-3801
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MCHIP
MCJ-138412
10/01/92–09/30/97
Project Director:
Kay H. Jones, L.C.S.W.

PROBLEM: In 1990, Grady Memorial Hospital in Atlanta, GA, referred 1,435 cases of suspected or potential child abuse or neglect to Child Protective Services. These numbers are, in large part, due to the prevalence of risk factors associated with child maltreatment among inner-city families. Child abuse and neglect are most likely to occur when family and social stressors outweigh supports. Published studies indicate that in order to decrease these devastating rates of child abuse and neglect, families demonstrating high-risk factors for these problems must receive an intensive, home-based intervention that begins at birth and continues throughout the child's early development. Grady Memorial Hospital provides services in an urban population, with many of its patients exhibiting one or more of these risk factors. More than 60 percent of families served by Grady have incomes below the poverty level. Between June 1993 and May 1994, 933 infants were born to first-time mothers under age 21 at Grady Memorial Hospital; in approximately 98 percent of these cases, the mother was the only parent. Although these at-risk pregnant women often receive comprehensive prenatal services from the Grady Health System, they very often leave the hospital following delivery with few, if any, services that address the risk factors for child abuse and neglect.

GOALS AND OBJECTIVES: The goals of Grady First Steps to Healthy Families are to:

1. Reduce the risk of child abuse and neglect in overburdened families with first-time parents under age 21 who receive prenatal care and/or deliver at Grady Memorial Hospital and reside in Atlanta;
2. Preserve the family unit;
3. Effect change in a multiracial/multiethnic, multicultural environment by promoting culturally aware, sensitive, and competent services and educational materials within the program; and
4. Provide a voluntary, community-based, comprehensive, universal, systematic program in collaboration with public-private agencies.

Seven specific and measurable objectives are to be achieved by 1997.

METHODOLOGY: Grady First Steps to Healthy Families addresses both primary and secondary child abuse and neglect prevention. Both involve community collaborations between Grady Memorial Hospital, neighborhood clinics, public health departments, social service agencies, and neighborhood/community groups. First-time mothers under age 21 who deliver at Grady Memorial Hospital will be identified and/or screened and assessed at the time of delivery by an early identification specialist to determine the intensity of risk factors associated with child abuse and neglect. New families at low risk are eligible for primary services and may receive telephone contact and/or limited home visitation for a minimum of 3 months. Families assessed to be at high risk for child abuse and neglect are eligible for secondary services, which provide intensive family support services in the home for 3 to 5 years. Primary services use volunteers and student interns, while the secondary component employs paid professional and student interns in the positions of family support workers. The program uses culturally competent personnel to offer family support services to new families.

EVALUATION: The program will be evaluated on both a micro and macro level. Statistics will be compiled monthly, quarterly, and annually to record the number of clients served by race, age, marital status, income level, and geographic location. Annual comparisons will be made between Child Protective Services referrals of families enrolled in the program and referrals of nonenrolled families. Client and volunteer satisfaction will be measured on a biannual basis using a satisfaction survey. The program will participate in the formal statewide evaluation of Healthy Families Georgia sites to be conducted by an independent research firm. The formal evaluation begins July 1, 1994. Participating families will be evaluated during the child's first year of life using six measures of change focusing on child abuse potential, maternal social support, parental stress, child development, home environment, and parental expectations of child development. An attempt to publish this information will be made at the time of evaluation completion. All program activities are monitored with the assistance of the Paradox Database system, which produces a monthly statistical report. All identification, screening, and assessment documents are monitored randomly on a monthly basis by the program director. Volunteers and family support workers use forms to record client contacts; these forms are reviewed by volunteer supervisors and the program director during monthly supervision sessions.

EXPERIENCE TO DATE: From June 1994 to May 1995, Grady First Steps to Healthy Families identified 902 first-time mothers under age 21, screened 603 of these families, and assessed 245 of the families. During this time, the program provided 352 families with family support services; 298 of these families received primary services, and 54 families received secondary services. The program served 66 percent of the families in its identified target population/geographic area during this period. Through the use of Spanish-speaking volunteers and student interns, the program has expanded its ability to serve Hispanic clients. In collaboration with Fulton County Public Library, a Books for Babies program has been implemented. This program promotes school readiness and positive parent-child interaction. A listing of medical homes (emphasizing sites where medicaid-accepting pediatricians are available) will be used to educate clients about their health care options. Staff members have been trained in the Nursing Child Assessment Satellite Training (NCAST) feeding and teaching scales, as well as effective black parenting.

Improving Health Care Access for Hispanic Families
Mercy Mobile Health Care
60 Eleventh Street
Atlanta, GA 30309-3970
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(404) 249-8940 fax

MCHIP
MCJ-138425
10/01/91–09/30/96
Project Director:
Noemi A. Carcar, M.D.

PROBLEM: Hispanic families living in metropolitan Atlanta lack access to a coordinated, culturally competent system of prenatal and pediatric care. The Hispanic population of Atlanta has grown dramatically in the past decade and now numbers more than 57,000. The number of Hispanic families in the three target counties—Fulton, DeKalb, and Cobb—has increased 77 percent, 109 percent, and 231 percent, respectively, in the past 10 years. The rapid demographic changes have placed burdens on the health care system and on service providers, who are often unprepared to handle the health care needs of these new residents. Hispanic families need assistance to bridge the barriers of language, information, economic, and cultural differences that may limit their access to health care.

The Asian population has also risen dramatically in the past 10 years—more than 300 percent. The Asian population, like the Hispanic population, is also faced with barriers to accessing health care services.

GOALS AND OBJECTIVES: Working in collaboration with local, county, and State health providers, Mercy Mobile Health Care will implement a comprehensive program that will:

1. Identify at least 50 Hispanic or Asian children with special health needs who require assessment, treatment, and followup services;
2. Improve the awareness and usage of coordinated health care services by at least 50 Hispanic, Asian, or African-American families with children with special needs;
3. Assist 50 pregnant Hispanic women in receiving a comprehensive range of assistance, including access to early prenatal care;
4. Develop a project evaluation plan that will provide needed baseline data; and
5. Improve the cultural awareness and sensitivity of health care providers regarding health issues affecting Hispanic and Asian families.

METHODOLOGY: The primary approach to identifying children with special health needs will be the use of mobile community-based children's screening and family primary care clinics. Children identified as having chronic medical care needs will be provided comprehensive referral assistance and support, including home visiting, transportation, and interpretation for appointments. A network of bilingual community health promoters (both Hispanic and Asian) will assist these families in accessing all needed health and social services. Health promoters will also assist pregnant women in enrolling in appropriate prenatal care and will carefully monitor women identified as being at high risk. Education that promotes healthful behaviors within the family will be provided through formal classes and regularly scheduled home visits.

EVALUATION: Careful records will be maintained on the number of clinics held and the number of patients seen. Individual patient intake forms will be used to monitor demographic information, special health needs, referrals made, and referral outcomes. Health promoters will maintain detailed activity logs on home visits made, type of referral assistance provided, and mileage. Information from the individual patient forms and the record of clinic activity will be tabulated monthly to determine (1) number of children screened; (2) number of children identified with special needs; and (3) number and source of referrals.

The evaluation plan will measure success in meeting specific process objectives that indicate the number of women and children who are provided health-related services and education. A plan to develop baseline data based on the result of activities since the start of the project will be implemented this year.

EXPERIENCE TO DATE: Since the project began in October 1991, it has been successful in reaching its objectives. Mobile clinics have been conducted at four community sites. A total of 1,922 children have been seen, with 304 identified as having special health needs. There are now 11 health promoters providing outreach and linkage for Hispanic and Asian families. A total of 524 pregnant women have been assisted in receiving prenatal care, with 100 percent enrolling in the first trimester. Due to the success of the program, we are open to any pregnant women, ending with 55 more in their second or third trimester. We have conducted 38 cultural sensitivity workshops for health care providers.

Enhanced Community Health Options (ECHO)
Ko'olauloa Healthy Tomorrows
Hawaii Department of Health
Maternal and Child Health Branch
741-A Sunset Avenue, #203
Honolulu, HI 96816
(808) 586-4410 or 733-9022

MCHIP
MCJ-158938
10/01/94–09/30/99
Project Director:
Loretta J. Fuddy, A.C.S.W., M.P.H.

PROBLEM: The health of children and their families is at risk in the community of Ko'olauloa on the island of Oahu, HI. Residents in this community are faced with many of the factors that are associated with poor health outcomes, including poverty, ethnic minority status, undereducation, and barriers to access to health care services in the community. Barriers to health care for residents of Ko'olauloa include lack of health care providers, fragmentation and lack of coordination of services for children, language and cultural barriers, and reluctance of many Ko'olauloa residents to seek assistance from anyone other than family or community. The Ko'olauloa Coordinating Interagency Team, composed of six community-based health service agencies, identified the following problems in the existing health care system: (1) Limited child health resources and lack of coordinated care; (2) low level of paternal involvement in the care of children and the resultant overburdening of mothers; and (3) lack of developmental/psychological assessments available in the community.

GOALS AND OBJECTIVES: The Ko'olauloa Healthy Tomorrows project seeks to address the system problems that currently exist and to improve access to child health services for families residing in the area. This goal will be realized through increased and coordinated outreach services, promotion of an integrated system of comprehensive health care, improved continuity of care through home visiting, increased paternal participation in accessing health care, and provision of developmental/psychological assessments of at-risk children. The project will work with the existing health care system and the community to provide a community-based, family-centered, comprehensive, and culturally relevant system of care.

METHODOLOGY: The project will increase and improve outreach services to families by coordinating with existing outreach programs. Project staff will work with families by providing case management, home visits, and linkages to medicaid and health services in a culturally relevant manner. A male social worker will work with the Enhanced Community Health Options (ECHO) Team. This social worker will help fathers to increase their participation in caring for the health of their families by providing culturally relevant health promotion and education, outreach, home visits, and positive role modeling. Children identified as at risk for developmental delay will be offered developmental/psychological assessments through contract services of a psychologist. To ensure continuity of health care, home visiting and care coordination services will be provided to at-risk families that are not accessing the health care system or are not maintaining followup care. The Maternal and Child Health Branch will provide the services of the ECHO Team—which consists of a program coordinator, medical social worker, public health nutritionist, nutrition aide, and clerical support staff—in collaboration with Public Health Nursing, medicaid, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Kahuku Hospital, and private physicians.

EVALUATION: The Ko'olauloa Healthy Tomorrows project will conduct process and outcome evaluation. The process evaluation will provide an overall assessment of the number and types of services provided, consumer satisfaction, number and types of referrals, number of and reasons for home visits, education provided during home visits, number of developmental/psychological assessments conducted, and demographics of the participating families and family members. The outcome evaluation will assess health status indicators of children, number accessing early and continuous family health care, immunization rate of 2-year-olds, number of child abuse reports, number of children screened for developmental delay, number of children receiving a developmental/psychological assessment, number of children participating in WIC and Early and Periodic Screening, Diagnostic and Treatment services, and paternal participation in family health care.

EXPERIENCE TO DATE: In summary, the social worker III has acclimated himself to his position within the ECHO team and the community. He has begun "talk story" sessions with seven dads/partners. In home visiting, he facilitates ICMQs, with an opportunity to assess health and social needs. The ECHO team has successfully linked community social and health service agencies for coordination and will continue monthly meetings. Two community psychologists have been contracted to conduct developmental assessments, and a speech pathologist is on contract. One developmental assessment and one speech pathology evaluation have been successfully completed.

Home Visitor Services for Pregnant/
Parenting Substance Abusers
YWCA of Pocatello
454 North Garfield
Pocatello, ID 83204
(208) 232-0742

MCHIP
MCJ-168010
09/30/2000
Project Director:
Sherri Molina, L.S.W.

PROBLEM: The most important lesson to draw from the medical and social data about maternal substance abuse is that addiction to both legal and illegal substances and a woman's entire lifestyle have serious implications, not only for a women's health and well-being, but also for the health and well-being of her children. Maternal substance abuse during pregnancy by almost any measure is a source of significant infant morbidity and mortality that presents serious concerns for our society.

Children who live with substance-abusing parents are at risk of physical and emotional harm. In Pocatello (southeastern Idaho), there were 1,041 reported cases of child abuse/neglect in 1994. Although official statistics tracking the number of child abuse/neglect cases directly or indirectly linked to substance abuse caregivers are not tracked by the Idaho Department of Health and Welfare Region VI Child Protection Services, unofficial reports by supervisors of Intake and Treatment Services indicate that fully 75 to 80 percent of cases involve some form of substance use.

In 1994, the State of Idaho established a Perinatal Abuse Planning Group to assess the unmet needs and problem areas for pregnant substance users statewide. Areas of concern that the planning group identified include:

1. Funding is inadequate, inflexible, and not targeted to the prevention and treatment needs of women, children, and families affected by the use of alcohol, tobacco, and other drugs; this results in inadequate services.
2. Treatment for women with children in Idaho is not structured to include children and does not ensure the full range of services that address their biopsychosocial needs and support them to successfully live drug-free lives.
3. Lack of information and networking between the public and private sectors results in a lack of coordinated service delivery and client access, therefore women and families do not receive comprehensive, culturally sensitive services.
4. Lack of coordinated linkage among primary health care, mental health, and substance-abuse treatment providers interferes with effective screening, assessment, and treatment of high-risk women and their children; therefore, women and families do not receive comprehensive, culturally sensitive services.

GOALS AND OBJECTIVES: Project goals are to:

1. Identify 30 clients in year 1, 30 clients in year 2, and 30 clients in year 3 from the at-risk target population for services; and
2. Provide home visitor services to address the needs of substance-abusing parents.

Objectives of the project are to provide:

1. In-home education and support services to assist parents in acquiring parenting skills, learning about child growth and development, and responding appropriately to the behavior of the children;
2. Early developmental screening of children birth to 5 years to assess and identify needs for appropriate referral;

3. Use of appropriate Healthy Families America concepts for implementation of outreach, home-based services to high-risk families through the child's fourth year of age;

4. Referral to and coordination of community services for families that include health care, substance abuse counseling, mental health care, employment development and training, child care, child development programs, nutrition education, peer counseling, crisis intervention, education services, and transportation;

5. Followup services and case management to ensure that necessary services are received and effective;

6. Child care services while the parent attends substance abuse or parenting classes, or medical appointments;

7. Respite care for children to reduce parental stress and alleviate crisis situations; and

8. Transportation to and from appointments when necessary.

METHODOLOGY: The project will develop, implement, and evaluate in-home services for pregnant/parenting substance users. The program will emphasize early identification and intervention, followed by intensive and prolonged visits, coupled with referrals to other local resources. Project referrals will be obtained from the State-funded substance abuse treatment program, Bannock Prenatal Clinic, and the Southeastern Idaho District Six Health Department.

All potential program participants will be evaluated by a qualified substance abuse treatment provider for level of substance abuse involvement. Once the assessment has been completed and a referral has been deemed appropriate, the YWCA director of youth and family services will be contacted to schedule an intake interview. Home visitors will conduct home visits with each client/family at a minimum of once a week.

EVALUATION: Evaluation procedures will cover four domains: Development of appropriate baseline data; process evaluation to answer questions in relation to how consistently the program was, or could be, delivered and how well it was received; effort evaluation to answer questions related to the cost per client of delivering each program component; and outcome evaluation to answer questions related to the impact of the program.

Malheur Maternity Project
Valley Family Health Care, Inc.
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Payette, ID 83661
(208) 642-9376

MCHIP
MCJ-168029
10/01/91–09/30/96
Project Director:
Royalynn Case, M.S.

PROBLEM: Although access to perinatal care has been increased through the operation of the Malheur Maternity Project (MMP), many pregnant women in Malheur County, OR, and Payette County, ID, are still not receiving prenatal care early in their pregnancy. Over the past 7 years, the number of first trimester enrollees in the service area has declined by 20 percent to 55 percent overall.

GOALS AND OBJECTIVES: The Malheur Maternity Project seeks to increase access to comprehensive MCH care, to provide individualized and continuous case management to pregnant and postpartum women and their newborns, and to implement planned and systematic educational programs to stress the importance of early and adequate prenatal care and child care.

METHODOLOGY: MMP has employed three certified nurse midwives to increase the capacity of the existing perinatal care system. MMP continues to participate with other community efforts to recruit new health care professionals who will provide maternity care. MMP promotes linkages and coordination among regional, State, and local resources and provides bilingual and bicultural case identification, risk assessment, and ongoing case management to pregnant women. To encourage early and adequate prenatal care, MMP maintains a high profile among service-providing agencies, promoting early entry into care. Networking is a continual process. Individual educational activities are focused toward each woman and her support system. A full-time case manager promotes and tracks followup care of both mother and child.

The participation and variety of individuals and agencies who make up MMP is the very strength of the project and concept. These members include the seven area physicians who have obstetrical privileges, Holy Rosary Medical Center, the Malheur County Health Department, Valley Family Health Care, Inc., and the Lewis and Clark Chapter of March of Dimes. The expertise and concern of the individuals involved and the existing spirit of cooperation have enabled MMP to succeed in improving the quality and quantity of MCH services in Malheur and Payette Counties.

EVALUATION: The MMP board of directors meets monthly and monitors MMP activities and utilization. Demographic data of MMP patients are reviewed annually, including trimester of entry, age, county of residence, ethnicity, education level, and payment status. These data are compared with parallel information on the general population in the service area. Any changes are also monitored and appropriate modifications are made.

Overall project evaluation will look at both outcome and process. Outcome will be evaluated using objective data. Vital statistics from 1989 for both Malheur and Payette Counties will be used as baseline data. MMP patient data as of December 31, 1990, will also be used as baseline data against which to evaluate specific outcomes. Specific health indices to be evaluated include trimester of prenatal care entry, birthweight, infant mortality, and neonatal and postneonatal deaths. A system has been implemented to track postpartum followup of mothers and infants. Baseline data are being collected on the number of women and infants who secure care at a local physician's office or clinic.

Process evaluation will be accomplished through key informant interviews of patients, policy board members, project staff, physicians, advisory committee members, elected public officials, and personnel of community agencies. This evaluation will analyze the procedures, protocols, public education campaigns, personnel effectiveness, and project mission and goals.

EXPERIENCE TO DATE: Since October 1991, when the Healthy Tomorrows Partnership for Children Program at the Malheur Maternity Project began, through May 31, 1995, 1,223 women have been accepted into care at MMP. MMP clients have had a total of 809 babies. Of these 809 deliveries, 75 percent were by certified nurse-midwives. Eighty-nine percent were normal spontaneous vaginal deliveries and only 11 percent were cesarean sections. The average birthweight has consistently been 7 pounds, 8 ounces. Thirty-four percent of the women accepted into care have been 19 years of age or younger, and 15 percent have been 17 years of age or younger. Thirty-five percent of the women were migrant or seasonal agricultural workers.

AAP/MCHB Collaborative Agreement to Promote Pediatric Provider Participation in the Healthy Tomorrows Partnership for Children Program
American Academy of Pediatrics
141 Northwest Point Boulevard
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(708) 981-4729

MCHIP
MCU-176057
10/01/91–09/30/96
Project Director:
Sherry Lyons, M.A.

PROBLEM: Although America's children and their families are generally healthier today than they were 50 years ago, millions have not benefited equally from advances in medicine because of inadequate access to appropriate medical care. Efforts to address health care problems among the populations at highest risk are hindered by the fact that more than 11.8 million children under age 21 lack health insurance. Medicaid is the largest program in the United States to provide medical care to women and children who lack private insurance and live in poverty. However, while program expansions continue to increase the number of eligible children, low reimbursement and administrative burdens are responsible for a continuing decline in pediatrician participation in the program.

GOALS AND OBJECTIVES: The American Academy of Pediatrics (AAP) will establish a functional collaboration with the Maternal and Child Health Bureau (MCHB) by assisting with administrative and technical assistance activities related to the Healthy Tomorrows Partnership for Children Program (HTPCP). AAP goals for this collaboration are to (1) promote problem solving at the community level; (2) encourage and facilitate pediatrician involvement in community-based programs that provide comprehensive, family-centered, culturally relevant care for underserved children; and (3) encourage private sector and other support for improved coordination of and access to health resources at the community level.

Program objectives are to (1) assist communities in establishing new community-based programs that provide comprehensive, family-centered, culturally relevant care to underserved children; (2) provide ongoing consultation and guidance to HTPCP projects; (3) advocate for replication of successful public-private partnership models demonstrated; (4) inform AAP members of opportunities to apply for HTPCP grants; (5) facilitate the involvement of AAP chapters in HTPCP projects; (6) assist in assessing the impact of HTPCP projects in the communities; (7) provide pediatric consultation and assistance to the MCHB as requested; (8) provide public relations assistance to HTPCP projects; and (9) facilitate coordination of health resources in communities in which HTPCP projects are located.

METHODOLOGY: HTPCP is a collaborative AAP–MCHB grant program that provides financial support and technical assistance to innovative community-based projects that use cost-effective approaches, foster cooperation among public and private community organizations, involve pediatric health professionals, and ensure access to comprehensive health care for underserved children and their families. AAP was intrinsically involved in the development of HTPCP and has been collaborating with MCHB on program activities since it was established in 1989. The primary activities AAP will carry out during each HTPCP application cycle are to assist MCHB in providing technical assistance and in disseminating the Grant Application Guidance; publicize the cycle among AAP members and others who have expressed an interest; encourage AAP chapters to participate in developing application proposals; and provide MCHB with logistical support for review panel meetings.

In providing technical assistance to funded HTPCP projects, AAP will: Under the direction of MCHB, arrange/participate in technical assistance visits to HTPCP projects as an expert resource to achieve program goals; provide logistical support for meetings of the HTPCP Advisory Committee and the project directors; encourage collaboration between HTPCP projects and local AAP chapters; and disseminate information about successful public-private partnership models demonstrated by HTPCP projects. All AAP activities will be conducted under the oversight of the AAP Project Advisory Committee on Community-Based Programs, composed of AAP members who are recognized nationally as having expertise in planning and implementing community-based programs.

EVALUATION: Evaluation activities, to be implemented under the guidance of the Project Advisory Committee, will focus on assessing (1) whether AAP collaboration on HTPCP has involved pediatricians in community-based efforts for the first time; (2) the level of AAP chapter and member involvement in HTPCP projects; (3) whether AAP collaboration on HTPCP has been beneficial for those who participated in the application process; (4) whether the technical assistance visits conducted by AAP were beneficial to HTPCP projects; and (5) whether HTPCP addresses the barriers pediatricians cite as preventing them from participating in community-based child health service programs.

EXPERIENCE TO DATE: Since October 1, 1991, AAP has responded to 905 technical assistance requests from potential HTPCP applicants and has distributed more than 3,000 copies of the Grant Application Guidance and other materials to promote the development of community-based maternal and child health improvement projects. AAP also has responded to 60 technical assistance requests received from HTPCP projects and has provided onsite assistance during 9 national AAP meetings. Project Advisory Committee members and AAP staff have attended the HTPCP project directors' meetings held in 1992, 1993, 1994, and 1995, and have provided public relations information to new projects each year. Technical assistance visits were conducted to 7 new HTPCP projects in 1992, 16 new projects in 1993, 10 new projects in 1994, and 10 new projects in 1995. Eight followup visits to 5th-year projects were made in 1994, and seven were made in 1995. Reports that include recommendations for the projects have been developed by the technical assistance visit teams that conduct these visits. AAP requests a written response, addressing recommendations in the technical assistance visit report, from project staff.

A letter from the AAP president was sent to a targeted group of about 10,000 AAP members and other health professionals to announce the start of the 1992, 1993, 1994, and 1995 application cycles. Information was sent to AAP chapter presidents and vice presidents and to Community Access to Child Health Facilitators to encourage their involvement. Presentations on HTPCP have been held during four national AAP meetings.

A survey of 1989 and 1990 HTPCP applicants was conducted in 1992. Data obtained from the survey have been analyzed, and a manuscript has been developed. A survey of HTPCP project directors was conducted in 1993. This survey asked project directors to assess the impact of HTPCP technical assistance visits and the level of pediatrician involvement in their programs. All respondents indicated a pediatrician was involved in their project in some capacity. In addition, a survey of 1,627 AAP fellows was conducted. Responses received numbered 1,060; 9.5 percent of the respondents were very, somewhat, or vaguely familiar with Healthy Tomorrows, and more than half (56.1 percent) said they participated in community-based activities. About 40 percent of respondents said they would like to spend more time in community-based activities; the most frequently mentioned reason for limiting participation was lack of time (83.6 percent).

Infant and Family Followup Program
University of Chicago
Woodlawn Maternal and Child Health Center
950 East 61st Street
Chicago, IL 60637
(312) 702-0440

MCHIP
MCJ-178531
10/01/91–09/30/96
Project Director:
Karen Walsh, M.D.

PROBLEM: Low birthweight infants often suffer from a variety of problems, including mental retardation, cerebral palsy, epilepsy, learning disabilities, and other significant disabilities. The most severely affected are those infants born weighing less than 1,500 grams. For our population, as many as 80 percent are born to families without health insurance or other financial resources to care for their special needs.

The importance of preventive medical care for high-risk families is well documented. Unfortunately, the economically disadvantaged are the least likely to sustain participation in preventive health care or social service programs. There are many reasons for this failure, including lack of trust in health care providers; failure to recognize or understand the benefit of such a relationship; inadequate transportation; poor communication skills; and the fragmented nature and confusing array of social and health services. In order to overcome these barriers, families and service providers need extensive education, and effective partnerships must be forged between health care and social service agencies.

GOALS AND OBJECTIVES: The Infant and Family Followup Program (IFFP) is designed as a comprehensive medical and social intervention model for families to improve the outcome for very premature, very low birthweight infants, to actualize the maximal potential function of these children in family units later in their lives, and to prevent the birth of low birthweight infants in the future by encouraging family planning. Its objectives are to (1) coordinate services of the major health care and social institutions and services interacting with eligible infants and families in the program; (2) identify, enroll, and provide comprehensive intervention and preventive care to at least 90 percent of all eligible infants born within the network and their families; (3) ensure attendance of enrolled families at an average of two or more support and education group sessions per year; and (4) implement a computerized system to track and monitor the visits made by infants and their families, the attendance of individual families in the parent group activities, and program attrition.

METHODOLOGY: The IFFP identifies and enrolls all eligible infants. These infants are born in the University of Chicago Perinatal Network and either (1) have a birthweight below 1,500 grams, or (2) are documented with or at high risk for neurobehavioral deficits. Annually, about 200 very low birthweight infants and 100 other infants at high risk for poor neurobehavioral outcome are entered in the program with their families. These infants are identified while in the neonatal intensive care unit (NICU) by the social worker or parent educator.

Clinic appointments are made by the social worker, parent educator, or program clerk prior to the infant's discharge from the hospital. The program clerk makes reminder phone calls 1 to 2 days before the appointment, and missed visits are rescheduled immediately. Primary, medical subspecialty, and developmental followup care are provided. Primary care is performed soon after discharge, as indicated (at 1, 3, 4, 12, 15, 24, 30, 36, 42, 54, and 60 months). Medical subspecialty care referrals are also made as indicated, with followup after such visits.

Developmental assessments include the following: Bayley Scales of Infant Development at 4, 12, 24 months adjusted age; speech at 9 and 18 months adjusted age; Stanford-Binet at 3 and 4 years of age; and the Wechsler Intelligence Scale at 5 years. Nutritional assessment is provided in every clinic session and supplemented by the parent educator in exit sessions with the family. A parent support group is available for parents to increase opportunities to share their experiences, foster healthy family relationships, and empower them to be better parents. Topics discussed in these sessions are selected by the parents.

EVALUATION: Program outcome objectives are monitored continuously and reported annually. These objectives include outcome indices for system use, health status, maternal reproductive behavior, collaboration among agencies, and commitment from the families. A computer data base tracks and monitors clinic and subspecialty visits, and sociodemographic information is entered into the data base. Monitoring efforts include review of monthly enrollment and clinic visit statistics, an annual report, weekly case review, monthly administrative meetings, and an advisory council that oversees program implementation and ensures continued participation of all partners.

EXPERIENCE TO DATE: Thirty Parents' Night sessions were held, with an average of six to seven people attending each session. These meetings gave parents the opportunity for informal discussion with the health professional while their children were in the NICU. A total of 227 infants were identified as being eligible for the program; 81 of them (36 percent) were seen in the clinic. Of those not seen in the clinic, 19 percent died, 13 percent lived too far, and 7 percent had their own physicians; others remained in the NICU, or their families received letters reminding them to schedule their first clinic appointment. Family interviews were continued by the social worker, who used the Family Profile Questionnaire in order to obtain sociodemographic background information and maternal pregnancy histories. A total of 62 clinic sessions were held; the participation rate was 60 percent. The University of Chicago Children Adult Resource Education and Support (UCCARES) Advisory Council continued its recruitment for parent members, with a clothing drive, speakers bureau, ICN alumni party, and gift pack.

Graduates of the neonatal intensive care unit are at increased risk for morbidity and mortality and definitely need solid social and pyschosocial support coupled with services for their complex health care needs. The IFFP was planned as an early comprehensive health and social intervention program for families to improve the outcome for very premature, very low birthweight babies; to help these children reach their full potential later in life; and to prevent future low birthweight babies by encouraging family planning. Parenting resources for these families, including education and peer support groups, are known to be necessary parts of effective care coordination. Care coordination needs to be coupled with a sturdy family support group that enhances parents' ability to use social and health resources.

Luz del Corazón
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MCHIP
MCJ-178502
10/01/92–09/30/97
Project Director:
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PROBLEM: Prior to the creation of Luz del Corazón, no bereavement services were available to Hispanic families who were having difficulty resolving their grief following the death of a child. Unresolved grief can lead to psychosocial problems that can affect family members' well-being throughout their lives.

GOALS AND OBJECTIVES: This preventive project is expected to decrease the incidence of dysfunctional physical, emotional, and social changes that arise in surviving Hispanic siblings and their families after the death of a child. It will also increase the accessibility and use of bereavement services for Hispanic families in the metropolitan Chicago area by developing a program that is culturally sensitive and that can be replicated in the Hispanic community.

Activities to accomplish these goals include the following:

1. Develop collaborative strategies with staff from Hispanic community organizations to identify existing bereavement services and deficiencies;
2. Create and implement a culturally sensitive bereavement program;
3. Secure long-term funding;
4. Evaluate the program and report findings;
5. Document changes in the health status of grieving children; and
6. Offer to train representatives from Hispanic organizations to replicate the program.

METHODOLOGY:

Objective 1:	A community advisory committee has been created that meets quarterly and includes representatives from the Hispanic community, social agencies, families, pediatricians, and other health care providers. This committee reviews program progress and provides input on program development.
Objective 2:	Systems have been created to identify, serve, and monitor appropriate families. A training model or volunteers who work with children's and parents' groups has been developed and implemented. Families joined the program in July 1994.
Objective 3:	Funding has been secured from corporations and foundations. Long-term funding is still being sought.
Objective 4:	Evaluation instruments have been identified or created, and they have been translated into Spanish as needed. These instruments reflect the impact of the program on the health status of participating children and reflect the appropriateness of program content.
Objective 5:	Preliminary reports will be prepared after the data collected have been analyzed. Information will be shared with professional and local communities.
Objective 6:	Training of interested community agency staff to replicate this model will be conducted in FY 1996.

EVALUATION: The principal and coprincipal investigators and the executive board are responsible for tracking project activities and assessing the extent to which the project objectives are being met. The community advisory committee provides the project with input into program content and appropriate cultural modifications.

The extent to which the program's intervention helps decrease the incidence of psychosocial changes in surviving Hispanic children after the death of a sibling will be assessed by administering three evaluation instruments (the Hogan Sibling Inventory of Bereavement, the Child Behavior Checklist, and the Volunteer Observation of the Child). These instruments will be administered at three points in time: Before entering the program, after 6 months, and at the time of completion. In addition, monitoring of program content appropriateness will be conducted semiannually by using two instruments completed by parents and volunteers. Data analysis will be performed by compiling a descriptive profile that includes the following data: Demographic information, behavior trends (according to parental and volunteer observation), and children's grief experiences. As the sample size increases, analyses will be directed toward correlations of time spent in the program and increase in positive behavior, as well as differences across test administrations.

EXPERIENCE TO DATE: Luz del Corazón serves families through both biweekly support meetings and informal contacts. Program development has required ongoing program refinement. There has been fundraising and collaboration with participating families and Hispanic agencies. Identification and training of program volunteers and families is ongoing. Problems encountered have included a delay in project implementation due to staff turnover, and uncertainty of funds due to the length of time required for foundations to respond to funding requests. A new program coordinator has been recruited and trained, and ongoing fundraising is being conducted. Luz del Corazón was designed to address survivor issues resulting from the death of a sibling from organic or chronic medical problems. Local area networks have found that in the neighborhoods being targeted more children die from violence than from organic illnesses. The program coordinator conducted a needs assessment that confirmed the local area network findings. The program continues to focus on families of children who have died from illnesses or disease, as the professional literature indicates that mixing children who have experienced varying losses is not effective for participants. To address the broader community bereavement needs, the family and professional educational initiatives have been expanded to include issues related to violent death.

Healthy Children Project: School Drop-Out Prevention

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MCHIP
MCJ-208006
10/01/95–09/30/2000
Project Director:
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PROBLEM: Wichita's children are at risk. The economic well-being and health status of the children are deteriorating each year. The percentage of students graduating from Wichita high schools ranks among the lowest in Kansas and continues to decline. West High School, with an enrollment of 1,414 students for the 1993–94 school year, had 172 (12 percent) students drop out—an increase of 2 percent over the previous year.

Six elementary and two middle schools that feed into West High School have been chosen as the target area for the Healthy Children Project. Approximately 58 percent of the families with children attending the target schools live at or below an annual income of $25,000. Over 57 percent of the children live in single-parent households. Approximately 33 percent of the children are minorities; the largest minority group represented is African American. The average daily absenteeism rate is 11.6 percent at the two middle schools and 5.3 percent at the six elementary schools.

During the 1990–91 school year, routine vision screening in the target area identified 135 children with visual problems, but only 54 percent are known to have received care. Routine dental inspections identified 808 children with dental defects, but less than 10 percent of the children inspected (including those without dental defects) had access to dental care.

GOALS AND OBJECTIVES: Project goals are to:

1. Provide onsite comprehensive primary care services to improve the physical, mental, and dental health status of children attending middle and elementary schools in the target area and, in the long term, increase the graduation rate at West High School;
2. Motivate children and extended families to adopt healthy lifestyles;
3. Teach children and families how to use health care resources appropriately and effectively; and
4. Train pediatric residents, medical students, nurse practitioner students, and school nurses about school health, community pediatrics, and multidisciplinary team functioning.

The outcome objective is to provide primary care, dental, and mental health services to 3,600 children in the target area in the first grant year. Impact objectives are, by 1999, to:

1. Increase to 80 percent the proportion of children ages 2–12 who receive regularly scheduled medical services including appropriate screening and immunization;
2. Increase to 95 percent the number of children attending kindergarten through postsecondary school who have received the basic immunization series;
3. Reduce, among children ages 6–8, dental caries to 35 percent and untreated dental caries to 20 percent;
4. Increase to 50 percent the proportion of children who have received protective sealants on the chewing surfaces of permanent molar teeth; and
5. Decrease by 20 percent absenteeism related to health problems.

METHODOLOGY: The community-based, family-oriented school health center, located at an elementary school, will provide primary care, dental, and mental health services to children from eight surrounding schools. Transportation will be provided if needed. Approximately 3,600 children will be provided services the first grant year.

The center will be a satellite of the Wichita Primary Care Center, a federally qualified community health center. Cities in Schools, a dropout prevention program and partner in the project, has a full-time site coordinator at each school.

Pediatric residents, medical students, nurse practitioner students, and school nurses will receive training at the center about school health problems, community pediatrics, and multidisciplinary team functioning.

EVALUATION: The center will establish a baseline health status of the children and compare these variables over time to determine the center's impact on the students' health. The center will evaluate the number of children referred to other resources, followthrough, and the number of students seeking treatment for health conditions. The school attendance records of children seen in the center will be monitored to determine if attendance improves. A school health advisory board will monitor the center. The Wichita Primary Care Center agrees to an independent evaluation by the Healthy Tomorrows Partnership for Children Program.

Families in Transition
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MCHIP
MCJ-248327
10/01/91-09/30/96
Project Director:
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PROBLEM: Families with children constitute the most rapidly growing segment of the homeless population. Data for FY 1993 from the Department of Human Resources in Maryland indicate growth of the population of sheltered homeless children from 6,956 in 1991 to 12,770 in 1993. This age group accounts for 25 percent of the homeless served by shelters in Maryland. That health care specifically targeted toward homeless children is necessary is evidenced by literature suggesting these children have (1) an increased prevalence and severity of health problems; (2) substantially decreased opportunities for preventive health care; and (3) competing needs among their parents and family, which make preventive care a low priority.

It is the premise of Families in Transition (FIT), formerly known as Comprehensive Health Care for Homeless Children, that a focused yet encompassing interdisciplinary approach that allows for identification and treatment of the medical, psychosocial, and environmental needs of the child and family is an effective method for addressing the health status of homeless children.

GOALS AND OBJECTIVES: The goals of the FIT program are as follows:

1. To provide a centralized health care source that employs a core management team skilled in eliciting and managing the multiple problems of homeless families as well as aggressive outreach and tracking of these families;
2. To help parents negotiate barriers that impair access, and to facilitate parental management of family needs to empower parents to attain self-sufficiency; and
3. To create a knowledge base concerning the health status of homeless children in Baltimore City.

METHODOLOGY: A collaborative effort with Health Care for the Homeless (HCH), Inc., has been established to draw on the expertise of that organization and to avoid duplication of services for the parents of patients enrolled in the FIT program. Children living in 10 family homeless shelters and transitional housing in Baltimore City and children referred from the University of Maryland Pediatric Emergency Room, Nursery, and Pediatric Ambulatory Center comprise the patient population. The children remain in the system 1 year after stable housing is established, at which time families are referred to a health care site in close proximity to their home.

Patient care activities begin with an initial two-visit intake during which the patient and parent are interviewed and/or evaluated by a pediatrician, a psychologist, and a social worker. On the basis of intake results a problem list is generated from which all case management activities stem. Children may receive onsite individual or family counseling with a behavioral pediatrician. Parents in need of support services or health care receive care from HCH, Inc., or medical specialists on the University of Maryland campus. These services are coordinated by each family's social worker or nurse-practitioner.

EVALUATION: Tracking of project implementation occurs via a number of quality assurance measures to document chart completion and effective case management. Evaluation of the success of the project occurs through (1) the extent of the data base of medical and social problems of the children; (2) changes in parameters of child health status (immunization rates, hospitalization rates, and emergency room visits) and family functioning (ratings of stress indices, parental satisfaction, and the child's mental health and the percentage of appointments kept); and (3) assessment of the program to deliver the services proposed (attrition rates of clients, enrollment of all eligible families into Aid to Families with Dependent Children, parental satisfaction with the program, and lower rates of emergency room use and hospitalization).

Evaluation of the effectiveness of the FIT program has primarily relied on the close monitoring of clinical measures. Both medical data and psychosocial data indicate that the program has been successful in achieving its goals and objectives. A small subset of families exiting the program have completed a standardized exit interview with data indicating decreased parenting stress levels and reduced behavioral problems in their children. A former employee of the program is currently proposing a dissertation project that will attempt to identify family and individual patient variables at entry into the program that differentially predict both basic medical and psychosocial outcomes. Grant proposals will be submitted in an attempt to obtain extramural funding to support a more controlled evaluation of the FIT program in the future.

EXPERIENCE TO DATE: Outreach continues to shelters for the purpose of health assessments, health education, and referrals. An advisory board, formed during the planning phase of the project, consists of the project team and representatives from city and State agencies providing services to homeless families. Problem solving has been focused on funding, public relations, linkages, and strategic planning. Program structures have been developed to enhance efficiency and to further integrate the project into pediatric primary care services in a large university-based clinic.

Healthy Tomorrows Parenting Program
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MCHIP
MCJ-248326
10/01/93–09/30/98
Project Director:
Lauren M. Jansson, M.D.

PROBLEM: The incidence of substance abuse in women of childbearing age is increasing. Consequently, an increasing number of children are being born to substance-abusing mothers. Children born to drug-abusing women are at risk for multiple health problems, developmental disabilities, and emotional/behavioral dysfunctions. Substance-abusing mothers often have multiple factors that prevent them from good parenting. Some of these factors are their origin from families with multiple problems, poor parental role modeling, sexual victimization, and poor self-esteem. Also, substance-abusing families often live in hazardous areas in abject poverty. It is evident that a combination of maternal and neonatal factors can seriously hamper the quality of the mother-infant relationship at a very early and critical stage in the child's development. The extent of the role of the environment in the disabilities suffered by children affected by substance abuse remains unclear, but recent literature has shown that intensive intervention can reverse the effects of perinatal drug exposure.

GOALS AND OBJECTIVES: The Parenting Skills Training Program for Substance Abusers program will:

1. Improve parenting skills among drug-abusing women through the development and implementation of a parenting curriculum, group educational sessions, and individual intervention/instruction sessions;
2. Improve the drug-abusing mother's self-concept in the role of motherhood and enhance her maternal appreciation of the child's development by assessing the child's behavior and development in the presence of the mother;
3. Facilitate mother-infant interaction by teaching the mother to recognize the competencies and needs of the child by assessing the child in the presence of the mother; and
4. Improve the cognitive, emotional, and social development of the drug-exposed child by increasing the mother's awareness of at-risk situations.

METHODOLOGY: The parenting project will be integrated into the Center for Addiction and Pregnancy (CAP) of the Francis Scott Key Hospital, Baltimore. CAP is an urban, community-based center that integrates enhanced prenatal and other medical care onsite with specialized substance abuse treatment services. In addition, comprehensive pediatric care is provided, with preschool-age children enrolled in onsite developmental play programs. To achieve its goals and objectives, the project will:

1. Develop and implement a parenting curriculum, adapted to each phase of the drug-using woman's treatment, that encompasses areas affecting the child's physical, emotional, and intellectual growth;
2. Conduct group education sessions covering topics such as physical care, motor and sensory stimulation, promotion of communication and language, enjoyment of the child, and consistent limitation and approval;
3. Administer various developmental and behavioral screening tools to the child in the presence of the mother during individual intervention/instruction sessions;
4. Instruct the mother to evaluate her child's development to enable early detection of developmental delays; and
5. Provide parenting evaluations and instructions during home visitations.

EVALUATION: Evaluation of the mother-child interaction will be performed using the Nursing Child Feeding Assessment Scale. Individual children's development will be assessed using the Neonatal Behavioral Assessment Scale and the Denver Developmental Screening Test. Baseline data collected during the first assessment will be compared with longitudinal data collected during followups. Comparisons between baseline and longitudinal data will be made to determine the effectiveness of the program in the mothers as well as the children. The parenting curriculum will be evaluated using the following outcome measures: (1) Attendance at sessions, (2) retention time in the program, (3) interest and participation in the activities, (4) acquisition of new knowledge, (5) level of awareness of child development issues, (6) changes in attitudes, (7) promotion to advanced phases of the program, and (8) reduction of drug use.

EXPERIENCE TO DATE: The Healthy Tomorrows Parenting Program (HTPP) at CAP is now entering its third year. Approximately 50 percent of the parenting curriculum manual has been completed. In the last year of operation, 349 individual sessions have been performed, and a total of 110 new children were assessed. Group parenting sessions are ongoing; 197 were conducted in the last year. Pediatric residents for the Johns Hopkins School of Medicine received individual didactic sessions with the parenting coordinator, and annual meetings of the HTPP were begun in June 1995. Materials relating to HTPP were presented at a regional child care conference in May 1994 and 1995. Finally, data from the parenting questionnaire were presented at a national drug abuse prevention conference in June 1995.

Deaf Family Clinic: Health Care Promotion for Deaf Youth and the Children of Deaf Parents
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MCHIP
MCJ-258116
10/01/92–09/30/97
Project Director:
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PROBLEM: Through the Deaf Family Clinic (DFC), children who are deaf or hard of hearing or who come from families where one or both parents are deaf or hard of hearing are offered primary and tertiary care services in an environment sensitive to their communication needs. In the past, failure to recognize the linguistic, cultural, and technological needs of these children put them at risk for stigmatization, poor compliance, personal hopelessness, failure to comprehend medical information, and dissatisfaction with experiences within the medical system. In addition, infants born with significantly abnormal hearing may suffer needless delay in identification through gaps in implementation of recommended newborn screening programs. We estimate that in the greater Boston area there are approximately 1,500 to 2,000 children and about twice that number of adults with hearing significantly diminished to the point of posing a barrier to receiving optimal health care.

GOALS AND OBJECTIVES: The five major goals and principal objectives of the DFC project are as follows:

1. Improve access to all elements of the health care system for people in our target population who are deaf or hard of hearing. We will eliminate the need for outside or family-member interpreters by providing full access to foreign-language interpreters for all families and by opening a school-based program at a local school for the deaf.
2. Improve the health status of children who are deaf or hard of hearing or whose parents are deaf or hard of hearing. Specific objectives here are to guarantee equal access to anticipatory guidance for these patients, measure functional health status reports from parents, and track progress of patients with chronic conditions such as asthma.
3. Improve the level of patient and parent satisfaction with the pediatric care delivery system. We have established representative advisory boards, improving communication and confidentiality and tracking serial measures of satisfaction objectively.
4. Enhance these families' understanding of their children's medical problems and improve their management and advocacy skills. We will provide both face-to-face education and innovative videotaped educational materials. We will monitor participation of family members in clinic visits and utilize community consultants to help us function best with our clients.
5. Improve access to and satisfaction with adjunctive treatments such as mental health consultations and educational testing units. Our social worker will provide direct mental health services and will make appropriate referrals to deaf-sensitive consultants.

Overall, we plan to achieve these goals by providing an environment conducive to comfortable communication between patients and project staff, including having staff fluent in American Sign Language (ASL), amplification devices for use by people who are hard of hearing, and general knowledge and sensitivity to cultural issues within our target groups.

METHODOLOGY: The project is open to families living in the greater Boston area and to the families of students attending the Learning Center for Deaf Children school in Framingham. Advertising for the service occurs through the deaf press, parent organizations, personal appearances, and word of mouth. A multidisciplinary staff including deaf, hard-of-hearing, and hearing people delivers care in the communicative style preferred by consumers, with a staff interpreter to assist in situations where more than one language style is used. Emphasis is placed on patient education to bring the level of knowledge up to normal standards for our special populations. Detailed measures of satisfaction, health status, self-image, and interactive strategies will be conducted longitudinally. The community advisory boards will guide the efforts of DFC in directions most suitable for the concerned communities.

EVALUATION: Progress is discussed quarterly at our advisory board meetings and at least weekly with project staff. Staff collect data to demonstrate progress toward specific objectives and overall goals. A detailed set of evaluation instruments has been constructed and is currently being translated into ASL by media consultants and deaf communications experts. We will collect data for approximately 3 years to determine the efficacy and effectiveness of the DFC program.

Injury Prevention for Pregnant and Parenting Teens: A Home Visiting Model
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MCHIP
MCJ-258123
10/01/93–09/30/98
Project Director:
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PROBLEM: Injury is the leading cause of death in children ages 1–19. Sixteen million children are seen in emergency departments each year for injuries, and injuries account for 20 percent of childhood hospital admissions. Unintentional injury and death are consistently related to young maternal age; however, injury prevention efforts have not been specifically targeted to adolescent parents. There may be aspects of adolescent parenting styles that place children at increased risk for injury. In young children, most injuries occur in the home. Massachusetts has collected the baseline statistics on childhood injury on which nationwide risks are based, and has been a leader in the development of injury prevention efforts through the Statewide Childhood Injury Prevention Program (SCIPP). This program documented an overall incidence of injury of one in five children per year by a surveillance system capturing emergency room visits and hospitalizations.

Previous educational efforts to reduce childhood injuries have typically been able to raise a parent's awareness of potential hazards in the household but have had only modest effects on actual reduction of potential hazards in the home.

GOALS AND OBJECTIVES: The 5-year demonstration project has the following goals: (1) To reduce the risk of injury in the children of adolescent parents in the Adolescent Prenatal and Family Clinic at New England Medical Center (NEMC) through a model of home-based injury prevention; and (2) to improve the delivery of services to pregnant and parenting adolescents at our affiliated community health centers, especially around the areas of outreach and injury prevention. The objectives to reach these goals include increasing adolescent parents' knowledge about injury risks and effective parenting skills coupled with increased use of safety devices and practices. The project will assess the current adolescent services for pregnant and parenting adolescents at our affiliated health centers and incorporate home-based injury prevention into the Parent-to-Parent outreach worker curriculum.

METHODOLOGY: We have developed a home-based injury prevention model for high-risk adolescent families who receive care at NEMC in our Adolescent Prenatal and Family Program. Our model expands on the SCIPP model by providing longitudinal, developmentally based home visits specific to the needs of adolescent parents. A full-time lay outreach worker provides the home-based visitation, using materials and resources from SCIPP and the Injury Prevention Program developed by the Academy of Pediatrics that have been modified as needed for the target population of adolescent parents. Home visitation begins prenatally and continues for 3 years after the birth of the child. Strategies to reduce the risk of childhood injury include safety counseling regarding hazardous household practices, distribution and installation of safety devices, and home inspections to identify hazards. The home visitor provides education and modeling of effective parenting skills and serves in a mentorship role to the young parents.

We hypothesize that this model will be effective in making the home environment safer, reduce the risk of injuries, and serve as an entree to discussions around broader injury issues such as physical discipline and child abuse and interpersonal violence, including family violence and sexual abuse. In subsequent years of this project we will work with the pediatricians and the Parent-to-Parent outreach workers in 10 affiliated community health centers to provide training and technical assistance to improve delivery of services to pregnant and parenting adolescents, particularly in the area of injury prevention. The NEMC Adolescent Prenatal and Family Program and the community health center sites serve some of the most disadvantaged areas of Boston, and our target population can be described as young, low income, urban, and minority.

The larger statewide community of pediatricians will receive updates about the project through articles published in the newsletters of NEMC referring physicians, Tufts Associated Health Plan (a large health maintenance organization affiliated with NEMC), and the Massachusetts chapter of the American Academy of Pediatrics.

EVALUATION: The project director will be following a timeline to determine whether the project activities are being accomplished in a timely fashion. The home visitor receives direct supervision from the program's social workers once or twice a week and reviews home visit logs and any problems identified that require referral. The home visitor meets with the project director monthly and, for assessing program quality, submits quarterly summaries of activities, including number of home visits accomplished, qualitative information on barriers to implementation of the planned service, training needs, adequacy of supervision, and accessibility of clients. The home visitor participates in the monthly case management meetings of all providers in the Adolescent Prenatal and Family Program.

At entry, young women enrolled in the Adolescent Prenatal and Family Program will be (1) randomized to home-based injury prevention intervention or to a comparison group that receives the standard office-based injury prevention education, and (2) followed prospectively. The expectation is 30 to 35 clients in each group per year. The process evaluation will focus on documenting that the home visiting intervention has occurred as planned, and it will assess strengths and weaknesses of the program implementation and assess client response to the intervention. The outcome evaluation will compare the two groups for knowledge of hazards, use of passive safety devices, safety practices, reported injuries, and use of physical discipline. Because the intervention may have broader effects on the parent's sense of effectiveness as a parent, measures of self-esteem, social competence, and quality of life will be performed. Because the home intervention may link these young women to the overall Adolescent and Prenatal and Family Program more effectively, we will also compare standard outcomes for adolescent pregnancy and parenting programs that relate to pregnancy outcomes, birth outcomes, infant outcomes, and compliance with scheduled prenatal and well-child visits. Data sources include program intake and followup forms, home visitor logs, home inspections, medical record reviews, and questionnaires administered to all clients at 12, 24, and 36 months postpartum. Improvement in the ability of the community health center sites to reach and engage adolescents will be measured by documenting adolescent client volumes. Attendance at workshops and satisfaction surveys will be used to measure effectiveness of educational efforts.

EXPERIENCE TO DATE: At the time of this report (three-quarters through our second program year), 49 young women have been recruited and randomized to treatment or comparison groups. Our home visitor has worked with 25 adolescent families, and the first clients enrolled are just reaching the 12-month followup point. Four of the home-visited clients have dropped out of the program for the following reasons: Neonatal death (one client), child removed from mother's custody (one client), change in health provider to be closer to home (one client), and home visitor refused by parents (one client). Project staff have received assistance from the Massachusetts Department of Public Health, Division of Injury Prevention and Control (formerly SCIPP), and other agencies providing home visitation and injury prevention efforts. Initial qualitative information suggests that home visitation is an acceptable intervention for adolescent parents.

Mothers' Mentors Project
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MCHIP
MCJ-258124
10/01/93–09/30/98
Project Director:
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PROBLEM: Infant health and survival are high-priority health status problems in the Boston, MA, neighborhoods of Roxbury, Dorchester, and Mattapan. In these neighborhoods, the infant mortality rate is more than twice that in the remainder of the city. Another indicator of the health status of the preschool-age children in these three neighborhoods is their immunization rate. Less than 40 percent of all children ages 0–2 are fully immunized. Failure of preschool children to have routine immunizations suggests not only that they are vulnerable to outbreaks of preventable infections such as measles but that they may also fail to receive other forms of well-child care, such as developmental assessments and anticipatory guidance. The prevalence and severity of these prenatal and infant health problems, combined with socioeconomic pressures, a lack of support services, and significant barriers to health care, mandated a focus on and mobilization of local community resources to positively impact infant health and survival in the Roxbury, Dorchester, and Mattapan communities.

GOALS AND OBJECTIVES: One goal of the Mothers' Mentors Project is to employ 24 trained community residents as mentors each year to promote primary health care, knowledgeable use of health resources, and increased parenting and nurturing skills to a minimum of 48 women and 144 infants each year who are at high risk for poor health status. A second goal is to improve the health status, functional ability, and developmental capability of 144 infants and children in three predominantly inner-city communities of Boston. Objectives are to:

1. Ensure the early and continuous participation of 100 percent of all project-enrolled pregnant women in prenatal care and other needed primary health care services;
2. Ensure that 75 percent of all enrolled infants receive regular developmental screenings, all age-appropriate immunizations, and other necessary preventive health services;
3. Ensure that 75 percent of all enrolled infants receive regular primary pediatric care;
4. Ensure that 100 percent of participants are informed about comprehensive family care, health care, reproductive health care, self-care, and infant care and safety;
5. Ensure the availability of an ongoing interdisciplinary advisory network during the course of the project; and
6. Provide 10 monthly Pregnancy and Parenting Support Group meetings for project participants.

METHODOLOGY: The Mothers' Mentors Project links pregnant and parenting women of Roxbury, Dorchester, and Mattapan with mentors—women from the same neighborhoods who have had successful pregnancies and parenting experiences. Through one-on-one relationships, home visiting, parent education/skills development, support groups, and recreational opportunities, the mentors will provide health education; facilitate linkages to primary health care, pediatric care, and family support services; conduct referrals and advocacy as needed; and provide skill development opportunities for the young mothers.

EVALUATION: The outcome evaluation will include a quantitative data analysis as well as a qualitative analysis of baseline data, data collected in exit interviews, interviews with a subset of participants, and observations of project activities. This analysis will profile the overall health status of each participant and child, will present in-depth case studies of the participants, and will identify project-related activities and processes that impacted the health status and overall development of participants. Mentors are monitored through ongoing direct supervision, weekly support group meetings of the mentors, and project staff observation. When participants leave the project, the evaluator will conduct an exit interview. Data will be collected on outcome of the pregnancy, health care, health status of the participant, and reasons for leaving the project.

EXPERIENCE TO DATE: Recruitment and training of dynamic community women to serve as mothers' mentors has been an ongoing process. The key to the success of the project has been the hiring of a project coordinator, who provides leadership that inspires project participants to reach their fullest potential.

Pediatric Family Violence Awareness Project
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MCHIP
MCJ-258101
10/01/92–09/30/97
Project Director:
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PROBLEM: Women in the United States are more likely to be assaulted and injured, raped, or killed by a current or former partner than by all other types of assailants combined. In Massachusetts alone, 32 women and 14 children were killed in 1992 in families with a known history of domestic violence. Children of battered women are at considerably increased risk for child abuse, and domestic violence and child abuse occur in the same family in 40 to 70 percent of cases. A child's witnessing the abuse of the mother also has important short-term and long-term psychosocial sequelae; for example, men who have experienced victimization of their mothers are 1,000 percent more likely to hurt their adult partners. Yet health care providers have typically received little or no training in appropriate responses to women and children affected by partner violence.

GOALS AND OBJECTIVES: The 5-year project will (1) enhance the quality of health care services provided to battered women and their children by increasing the knowledge of primary care providers about family violence, its impact on the pediatric population, and resources for referral and followup; and (2) provide increased access to an ongoing, innovative pediatric service, the Family Advocacy Clinic at Neponset Community Health Center (NCHC) in Dorchester, MA, which conducts comprehensive health and psychosocial evaluations of children of battered women and provides safety planning and advocacy services to battered mothers.

METHODOLOGY: The Pediatric Family Violence Awareness Project is a collaborative effort of the Massachusetts Health Research Institute, the Massachusetts Department of Public Health (DPH) Bureau of Family and Community Health, the New England Medical Center (NEMC), NCHC, Carney Hospital, Boston City Hospital, and the Massachusetts Chapter of the American Academy of Pediatrics. Trainings will be provided to approximately 1,200 pediatric and perinatal health care providers throughout Massachusetts. Half-day and full-day trainings address warning signs of abuse, screening and documentation, safety planning, and community resources. One-hour and 2-hour workshops focus on special issues, such as adolescent dating violence or domestic violence and child abuse. Practice guidelines are reviewed through use of the new statewide protocol "Identifying and Treating Adult and Adolescent Battered Women and Their Children: A Guide for Health Care Providers," which was developed by the DPH Women's Health Unit. In project years 4 and 5, a special intensive seminar will prepare trainers to implement the project curriculums in their own settings throughout the State. In year 5, the project curriculum will be prepared for statewide and national distribution. Technical assistance is provided by the multidisciplinary Project Advisory Board, composed of health care providers and battered-women's advocates from a variety of settings.

EVALUATION: The number of providers who receive training, including their professional and demographic characteristics, is monitored through a questionnaire administered at the beginning of each training. These data are summarized and presented at quarterly meetings of the Project Advisory Board. The number of patients seen at the Family Advocacy Clinic, the services they receive, and the number of referrals to the clinic by training participants are logged and summarized annually. Monthly administrative meetings provide a means to continually monitor progress toward stated goals and objectives.

Training effectiveness is assessed through pretraining and posttraining questionnaires measuring knowledge, attitudes, practice skills, and satisfaction with training, and through a 6-month followup survey measuring practice changes. The number of providers who reported screening more than 80 percent of mothers and female patients for domestic violence increased from only 12 percent before training to 30 percent 6 months after training.

EXPERIENCE TO DATE: The project has developed and piloted a versatile curriculum consisting of 1-hour, 2-hour, 3.5-hour, and 6-hour seminars for pediatric and perinatal providers. The project trained 239 providers in year 1, 383 providers in year 2, and 706 providers in the first 9 months of year 3. Pretraining, posttraining, and followup questionnaires have been developed. Ongoing training and technical assistance to three Dorchester community health centers has facilitated development of new onsite domestic violence task forces and protocols in these health centers, as well as further collaboration among centers. Through a research grant from the Medical Foundation's Deborah Munroe Noonan Fund, project staff have launched a study in two community health centers to assess the impact on provider behavior of training alone as compared to training combined with onsite battered women's services. The Family Advocacy Program has provided clinical assessment and advocacy services to 49 mothers and children affected by domestic violence.

Preschool Asthma Education Project
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MCHIP
MCJ-258134
10/01/94–09/30/99
Project Director:
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PROBLEM: Pediatric asthma is an increasingly prevalent and costly public health problem. Children living in inner-city, disadvantaged homes show a higher prevalence of asthma and are disproportionately affected by asthma morbidity, including ill health and hospitalization. Current preventive asthma management strategies should minimize symptoms and school absence as well as virtually eliminate the occurrence of acute severe asthma attacks requiring emergency care and hospitalization. Still, school absence and hospital-based care is common among inner-city children with asthma. We have documented that at least 12 percent of 2,000 children enrolled in an inner-city Head Start program have known asthma with frequent symptoms and activity limitation. Use of preventive asthma therapy among these children was low, and their absences were 30 percent higher than of nonasthmatic classmates. We have also shown that asthma emergency room visits and hospitalization rates for children in the Head Start age group are particularly high. Multiple factors contribute to high prevalence and excessive morbidity of childhood asthma in the inner city. High levels of airborne particulates (including industrial and traffic-associated pollution) and environmental tobacco smoke in the home are recognized asthma triggers. In the inner city, household allergens relevant to asthma extend beyond the ubiquitous dust mite to inhalant allergens resulting from infestation of poorly maintained urban housing—namely mold, roach, rat, and mouse allergens. The episodic nature of asthma care in the inner city contributes directly to asthma morbidity and results in deficient asthma education of families for cooperative care. Specific educational resources designed for inner-city families with preschool-age asthmatic children are lacking.

GOALS AND OBJECTIVES: The goal of the preschool asthma education project is to reduce the excessive morbidity experienced by young, inner-city children with asthma who are enrolled in a Head Start program. Specific objectives are to:

1. Increase asthma care knowledge among participating parents and teachers;
2. Increase asthma preventive care visits to primary care providers by the enrolled asthmatic children;
3. Decrease asthma symptom levels among these children;
4. Reduce excess health care utilization (emergency room treatment and hospitalization) among enrolled asthmatic children;
5. Reduce asthma-related Head Start absences;
6. Reduce exposure to asthma triggers in the home; and
7. Increase family use of adaptive behavior regarding asthma.

METHODOLOGY: The 2,100 children enrolled in Action for Boston Community Development (ABCD) Head Start will be surveyed for asthma using routine health forms completed by the primary care provider as well as an additional parent questionnaire. Initially, separate focus groups of parents, teachers, and primary care providers of these children will meet to define their perceived educational and support needs. The results of the focus group sessions will be used to modify existing asthma educational curriculums developed for older inner-city populations. The project physician will provide comprehensive training to the team of Head Start nurses regarding pediatric asthma and project implementation. The Head Start family advocates and nurses will gather data on asthma symptoms and therapy, health care utilization patterns, family asthma knowledge, decision-making and adaptive behaviors regarding asthma, and exposure to asthma triggers in the home. Teachers will also be surveyed for asthma knowledge. The project physician and site nurse will meet with teachers at each site to discuss asthma and the educational project and to elicit their cooperation in reporting to the advocate any asthma symptoms observed in class. The nurse at each site will (1) meet with the family advocate each month to review absence data and asthma symptom levels, (2) meet with parents in a monthly asthma educational and support group, and (3) meet with asthmatic children in an asthma educational/hospital play session. The nurse, with physician backup, will be available through a daily "telephone hour" to the family of each asthmatic child. Primary care providers of enrolled children will be informed of the project and will be offered onsite continuing education about asthma management; for any child with excessive symptoms or apparent undertreatment, the project physician will visit the child's clinic for "academic detailing." The family advocate will gather data continuously regarding asthma absences, preventive clinic visits, and symptoms observed at school; for comparison, routine attendance logs for nonasthmatic children will be maintained.

EVALUATION: At the end of each Head Start year, family advocates and nurses will repeat data gathering from parents regarding asthma symptoms and therapy, family asthma knowledge, decision making and adaptive behaviors regarding asthma, and exposure to asthma triggers in the home. Teachers will be retested for asthma knowledge. At least once a month, cumulative data on asthma absences and health care utilization will be entered into data analysis programs and reviewed. Information obtained will enable an assessment of the impact on asthma morbidity of a comprehensive, sustained asthma educational and support effort integrated into an inner-city Head Start system. The program will result in the creation of methods and materials suitable for wide use in Head Start systems.

EXPERIENCE TO DATE: Children enrolled in ABCD Head Start during the 1994–95 year were surveyed for asthma. Four parent focus group sessions were held (two in English, one in Spanish, and one bilingual) to explore asthma-related needs of Head Start families. In addition to wanting more information about asthma in general, parents revealed a strong desire to be assured that Head Start staff could handle asthma symptoms, medications, and attacks competently, and expressed the conviction that asthma is highly individual. Clinicians of the asthmatic Head Start children were surveyed through mailed questionnaires on critical asthma management behaviors to be emphasized in the asthma educational project. Existing asthma educational materials for older inner-city populations were reviewed. Head Start-based asthma management and educational strategies for both parents and teachers are being devised in response. Asthma training was provided in workshops to the Head Start health managers and to over 250 teachers. Changes in asthma knowledge resulting from the workshops among these groups were assessed by questionnaire. Materials for health staff and teacher training and a project brochure were developed. The program will result in the creation of strategies and materials suitable for widespread use in Head Start systems.

Consultation Service for Children with Severe Chronic Illness
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MCHIP
MCJ-268509
10/01/92–09/30/97
Project Director:
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PROBLEM: Children with severe chronic illnesses or disabilities represent 2 percent of all children; there are 35,000 to 50,000 such children in Michigan. A large majority of these children lack access to effective primary care because of the complexity of their problems, the time involved in assessment of the children's and families' needs, the difficulty in finding local support services, and the inadequate level of reimbursement. As a result, such children lack any semblance of coordinated, comprehensive care; they also lack basic immunizations, appropriate nutritional assessment, anticipatory guidance, and even office care for intercurrent illnesses. Thus, many children with severe chronic illnesses receive expensive but inadequate health care services (a systems problem) resulting in impaired health, increased stress on the child and family, disordered educational experiences, and delayed functional development (a health status problem).

GOALS AND OBJECTIVES: The project's goals are to (1) increase access to primary care for children with severe chronic diseases, (2) assist primary care physicians in providing quality comprehensive care for children with severe chronic conditions, and (3) improve health status for these children. The objectives of the project include measurable improvements in health status, functional abilities, and developmental/educational capabilities of project children.

METHODOLOGY: Children with severe chronic illnesses in an 18-county region served by Michigan State University's College of Human Medicine are the target population. The children are recruited from private physicians, social agencies, district health departments, and local school districts. A total assessment of the child (and family) is done by a team consisting of a pediatrician, a clinical psychologist, a social worker, a nurse clinician, a nutritionist, an education specialist, and a physical therapist. The assessment produces an individual health plan (IHP) that delineates the problems and needs of the child and family, the goals to be achieved in the ensuing 12 months, the resources needed, and their location in the child's locale. This IHP is sent to the primary care physician and the local based services (LBS) coordinator for children with special health needs. Followup telephone consultation with the physician is available. Reassessment is done annually and a new IHP is developed.

EVALUATION: Process and outcome evaluations for the physician, child, and family are measured with questionnaires on physician attitudes and satisfaction; on the child's use of emergency services, hospitalizations, and days absent from school; and on the family's functional state and satisfaction. Disease-specific objectives in health status, functional abilities, and developmental/educational capabilities are established for each child and incorporated in the IHP. Project activities are monitored at specific intervals by project staff. Team process and progress toward project goals and objectives are discussed at team conferences and retreats. Individual files are reviewed annually.

EXPERIENCE TO DATE: The consultation model includes two or three visits with the assessment team to accomplish a comprehensive evaluation and to develop the IHP. Seventy-five children with a variety of chronic health conditions have been seen, involving approximately 90 visits in the 2-3/4 years of the project. Development of a new standardized format for the IHP, including appropriate language for families and professionals, is underway.

Madres y Ninos Colonia Health Program
Midwest Migrant Health Information Office
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MCHIP
MCJ-268007
10/01/95–09/30/2000
Project Director:
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PROBLEM: Information about health issues is almost nonexistent for low-income Hispanic residents of colonias in the Rio Grande Valley of Texas. Not only are the women and children largely unaware of the health services available, they are incapable of accessing them due to language difficulties, poverty, physical isolation, lack of transportation, fear of professional health providers, and misconceptions about routine health exams and procedures.

GOALS AND OBJECTIVES: The project goals are to increase:

1. Colonia residents' knowledge of health issues and available health resources; and
2. Colonia mothers' and children's access to needed health services.

Process objectives that measure the efforts of the colonia health workers are as follows:

1. Four health workers will perform initial health assessments with 150 colonia families; initial and subsequent questionnaires for each family will gauge health status before and after project intervention;
2. Health workers will provide referrals (at least 400), followups, and advocacy for these families;
3. Information on 10 maternal and child health topics, planned and presented by the health workers, will be added to the curriculum of Avance—a nationally recognized family support and education agency; and
4. Health workers will present group educational health sessions to 2,000 colonia residents in the homes of their friends and neighbors.

METHODOLOGY: The Midwest Migrant Health Information Office, which has an 11-year history of lay health promotion with migrant farm worker families and indigent communities from the Rio Grande Valley, will partner with Avance. Avance's program has identified serious health risks and problems amid this population but remains unprepared to deal with this need.

Health workers will be used to facilitate project goals. The health workers, many of them colonia residents, are migrant farm worker women who have extensive training in health issues and experience providing health education and advocacy for their peers. They have the same socioeconomic background as the families with whom they will be working; therefore they are able to present health information that is culturally and linguistically competent and easily understood. After an intensive 2-week training period, the colonia health workers will do individual initial health needs assessment of approximately 150 families participating in Avance's parenting and child development programs at two Avance sites in select colonias. Identified health needs will be addressed through referrals to health services, followup with families, and advocacy with health care providers.

Health education, facilitated by the colonia health workers, will be added to the topics addressed in weekly classes attended by Avance program participants. Educational sessions, attended by family members and friends, will be presented in the homes of Avance participants on health topics of interest to the group. Families will also receive ongoing individualized education and assistance.

Program activities and educational sessions will take place at Avance meeting centers located within select colonias. Transportation to the centers will be provided. No transportation will be required for group educational sessions because they will take place at the homes of participants, friends, or neighbors. Colonia health workers will help residents to use available transportation services or to organize neighborhood carpools to reach health services.

EVALUATION: Because commonly used pretests and posttests are inadequate assessments of changes in knowledge among participants with limited literacy skills, other methods for documenting changes in health knowledge and health status will be used. The following are practical and cost-effective documentation activities for the *Madres y Ninos* Colonia Health Program:

1. Colonia health workers will keep logs of their activities, recording anecdotes and encounters with and behavior changes in program participants;
2. Avance staff will complete evaluation questionnaires about observed health changes in program participants;
3. Avance staff will administer questionnaires orally to mothers participating in the program, and will document their comments regarding the program's effectiveness;
4. Health assessment forms will be completed for each family at the program's onset and again at its conclusion;
5. Health services received as a result of the program will be documented on the health assessment forms as a measure of increased access to health care; and
6. The number and topics of educational sessions presented by the health workers and the number of people in attendance, as well as tangible outcomes as a result of the sessions, will be carefully documented in group educational session forms and health workers' logs.

Air Care: Improved Asthma Management for Young Children and Adolescents

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MCHIP
MCJ-278510
10/01/92–09/30/97
Project Director:
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PROBLEM: Minneapolis Children's Medical Center is surrounded by an inner-city neighborhood that is characterized as the poorest neighborhood in the metropolitan area, with the highest rates of public assistance, infant mortality, and other indicators of poor health status. Overall, minority inner-city children living in poverty are affected at almost twice the rate of white children who live in larger, less crowded housing. Many of the children who are patients in the Children's Clinic and the TeenAge Medical Service (TAMS) have had excessive rates of hospitalization and emergency room use due to inadequate asthma management. The Air Care home care nurse augments the traditional medical staff by providing education and intervention efforts that deal specifically with the social and cultural factors unique to an inner-city population living in poverty.

GOALS AND OBJECTIVES: Over the 5-year project period, each participant in the Air Care project will show relative improvement related to his/her asthma condition. The project will:

1. Improve the appropriate use of health services, such as decreased visits to the emergency room and hospitalization, and the appropriate use of asthma management medication;
2. Increase the sense of well-being as perceived by the child, parent, and adolescent, including improved school attendance or decreased absenteeism;
3. Increase the skill and knowledge level of patients and their families about the disease; and
4. Address the social and environmental factors that contribute to the risk associated with asthma.

METHODOLOGY: In order to achieve the outcome objectives established for the project and for each participant, the following methodology has been followed:

1. Identify the inner-city children and adolescents most at risk. Enroll 25 participants, with 20 percent adolescents.
2. Integrate a home care nurse into a team of physicians, nurses, and social workers.
3. Continuously follow up in the homes of the families participating in the program.
4. Adapt program efforts to meet the needs of parents of young children with asthma and the unique characteristics of inner-city adolescents.
5. Use the "You Can Control Your Asthma" teaching materials developed by another federally funded project.

EVALUATION: Initially, a parent evaluation and advisory council were proposed as a means of providing feedback about the project's effectiveness. This technique did not prove workable, so a family feedback questionnaire has been developed that will be conducted one-on-one by nonproject personnel on a periodic basis. A community advisory council has been established that includes members from various health organizations with an interest in asthma management. A specially designed data base has provided the capability to monitor the progress of each participant and the overall extent to which the project is meeting the stated goals and objectives. The data base provides the mechanism to organize, maintain, and evaluate the baseline information collected for each enrolled participant.

EXPERIENCE TO DATE: We have found it very difficult to maintain stable and continuous involvement of participants. Fifty percent of the participants are adolescents. More adolescents have been referred than expected based on their extreme noncompliance with asthma management efforts. A total of 55 children have been referred to the Air Care program since February 1993. Thirty-four of these children have been enrolled in the program. Seventeen are currently being followed, and 17 cases have been closed (4 children have completed the program, 9 were lost to further followup, and 4 moved out of State). Eighteen children were referred but never enrolled because they refused to participate in the program, did not meet admission criteria, or could not be located.

Habitat Health Services
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MCHIP
MCJ-278009
09/30/2000
Project Director:
Malcolm L. McCutcheon, M.D.

PROBLEM: Adolescent mothers are at high risk for additional pregnancies, sexually transmitted diseases (STDs), emotional problems, and chemical abuse. They lack parenting skills and are at risk for abusing or neglecting their children. In addition, the children of these mothers are at risk for lasting health, cognitive, behavioral, and financial problems. Children born to young mothers are likely to have health problems during childhood and to be hospitalized. In addition, studies have shown that poverty in early childhood has negative long-term effects on educational, social, and economic attainments.

The Habitat Program in Duluth, Minnesota, seeks to expand services to the high-risk adolescent mothers, infants, and toddlers it currently serves by establishing Habitat Health Services (HHS). Habitat, a Duluth Public Schools' alternative high school track, provides a parenting class for adolescent mothers and in-school child care for their infants and toddlers. In addition, some students who are enrolled at Unity High School, an alternative program for students with behavior and/or emotional problems, are single mothers with young children. There are approximately 50 mothers with young children enrolled in Habitat and Unity who would benefit from better access to medical care.

These mothers and children are faced with enormous difficulties. All Habitat and Unity mothers are eligible for or receiving at least one source of public assistance. Forty-five percent of Unity mothers and 27 percent of Habitat mothers are minorities; 60 percent of Habitat children are minorities. A 1994 survey showed that Habitat mothers missed an average of 4.2 days of school in each grading period (6 weeks) due to their own or their children's illnesses and that Habitat children average 2.9 emergency room visits a year.

There are also problems in medical and other health care education programs and their abilities to train providers to address adolescent needs. This may be more of an issue in Duluth's community than for larger metropolitan areas that have established training centers and existing community programs and services. In Duluth, however, there are no school clinics and few adolescent community programs. The University of Minnesota Duluth School of Medicine believes it has a need to train its students to address the biopsychosocial needs of today's adolescents.

GOALS AND OBJECTIVES: The project goals and objectives are as follows:

Goal 1: Improve overall health of Unity and Habitat adolescent mothers and their children. Specifically, reduce average missed school days of these mothers due to infant, toddler, and mother illness.

Objective: By the end of the 5 years, the average number of missed school days of adolescent mothers due to infant, toddler, and mother illness will be reduced from 4.2 per grading period to 3 per grading period (29 percent improvement).

Goal 2: Improve access, continuity, and completeness of medical care for Unity and Habitat adolescent mothers and their children.

Objectives:

1. By the end of year 1, HHS will be available to provide regular onsite health care and age-relevant health education materials for Habitat and Unity adolescent mothers and their children.
2. By the end of year 2, HHS will be able to demonstrate consistent coordination of patient care with the students' private physicians.

Goal 3: Reduce the number of infant and toddler emergency department (ED) visits during the time the mother is enrolled at Habitat or Unity.

Objective: By the end of the project, the number of ED visits by Habitat and Unity mothers and children will be reduced by 25 percent.

Goal 4: Provide a realistic one-on-one adolescent and small child care teaching setting for medical and nurse practitioner students.

Objective: By the beginning of year 2, 12 local medical students and three family nurse practitioner students will rotate through HHS.

METHODOLOGY: With a pediatric nurse practitioner (PNP) as principal provider, and with a pediatrician consultant and linkages with multiple community organizations, HHS will provide an intensified care setting that will focus on health promotion and risk reduction for this at-risk population. HHS will be located at Unity and will be open Monday through Friday, 8:00 a.m.–12:00 p.m.

In addition to the PNP, a school nurse will spend 2 hours each morning at Habitat screening infants and toddlers, answering mother's questions and managing followup care. The PNP and school nurse will interact with students in a trusting environment and provide access to health care, answers to questions, and positive adult role models. The PNP will be medically supervised by the pediatrician consultant. The school nurse and PNP will become a link for the adolescents to their medical providers. HHS will provide treatment records and facilitate referral and followup care with the students' private providers to allow continuity and completeness of service.

General maintenance visits will cover wellness issues for the mother (e.g., nutrition, exercise, contraception, responsible relationships, STD detection and prevention, responsible use of chemicals) and for the child (e.g., child abuse and neglect prevention and screening, injury prevention, immunizations, nutrition, developmental issues). The PNP and school nurse will provide instructions appropriate to the adolescent's maturity level and be present to ensure patient understanding and compliance. Patient visits will be scheduled for 30 minutes to ensure enough time for the adolescent to work through all her questions and concerns and to allow ample time for the PNP to respond at a pace that accommodates the adolescent.

Health and parenting education will become a weekly component of Unity and Habitat curriculum for the project duration. Once a week, the health education classes at Habitat will be taught by community professionals including the PNP; health educators; community physicians; Special Supplemental Nutrition Program for Women, Infants and Children (WIC) counselors; social workers; and others involved in youth services. Unity mothers will be able to take elective health and parenting seminars offered after school and receive credit in family and child health care. The Habitat director will develop a curriculum and provide these classes.

EVALUATION: Evaluation will include both process tracking and outcome evaluations. Outcomes on days absent and number of ED visits will be tabulated using 1994–95 data as a baseline. Attendance, attitude, and knowledge of health education issues will be tested through the health education component. Habitat and Unity students will be asked to participate in focus group discussions on various aspects of the project. Services provided, tracking of referrals, and followup will be documented. Finally, medical and nurse practitioner students will provide qualitative information on their experiences through small group sessions with project staff.

North Star Elementary School-Based Community Health Center

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MCHIP
MCJ-278535
10/01/94–09/30/99
Project Director:
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PROBLEM: The health status of children in the Near North community of Minneapolis is among the worst in the city. This community has the highest percentage of low birthweight infants (11.5 percent) and the highest infant mortality rate (18.6 percent) of all Minneapolis communities. Only 50.9 percent of pregnant women in this community received prenatal care in the first trimester, and only 38.2 percent of 2-year-olds are adequately immunized.

The Near North community is one of the most diverse communities in Minneapolis. Nearly 60 percent of its residents are people of color, and more than 12 percent speak a language other than English at home. Poverty is a major problem in the Near North community; 62.5 percent of children under age 5 and 50.3 percent of children between ages 5 and 18 are below Federal poverty standards. Only two primary health care facilities are located in this area, and most of the community has been designated a Medically Underserved Area. Most health care efforts in the city of Minneapolis have focused on preschool children and adolescents. Elementary school-age children have been neglected and are one of the most underserved populations in the community. North Star School, which is located in the Near North community and has one of the largest kindergarten through third-grade student populations in the city, has felt the effects of this lack of care. More than 360 students (33.9 percent) had more than 10 absences during the 1991–92 school year, and 123 (11.5 percent) had more than 20 absences. Teachers report that many of these absences are due to lack of access to health care or to parents' inability to deal with the complexities of the health care system. Currently, no solution exists to this problem of lack of access to health care.

GOALS AND 0BJECTIVES: To improve the health status of children and their families in the Near North community, the Minneapolis Department of Health and Family Support (MDHFS) intends to build on its lengthy experience with adolescent school-based clinics and other community partnerships to establish a multidisciplinary and multiagency school-based clinic in North Star School. The objective of this clinic is to serve the students in North Star School and also to serve as a community clinic for other school-age and preschool children and their families who live in the community. It will also be a collocation site for an array of social services. By providing comprehensive health services to more than 1,000 children and their families, the clinic aims to:

1. Increase the immunization rate of 2-year-olds to 70 percent;
2. Decrease to less than 5 percent the number of students who enter kindergarten inadequately immunized;
3. Decrease by 25 percent the number of students who are absent more than 10 days during the school year; and
4. Improve the use of community-based health services.

METHODOLOGY: MDHFS will collaborate with two community-based clinics to staff a multidisciplinary clinic at North Star School. Various human service providers will also be collocated in the clinic. The clinic will be in operation during school hours and after school so it can serve North Star students as well as other children living in the area. Services to be offered to children and adults at the clinic include primary medical, dental, nursing, nutrition, social work, developmental screening, health education, and pregnancy testing and family planning services. Outreach workers from the community will provide home visits to enhance family use of the services provided by the clinic. Backup services will be provided by the existing community-based clinics that offer X-ray and pharmacy facilities. Contracts with the managed care plans in the county that serve the medicaid population will be pursued as a way to fund the clinic long-term and as a demonstration of how to link school-based clinics and managed care. MDHFS is the local Title V agency for Minneapolis. The program will collaborate with the Minnesota Department of Health's Maternal and Child Health Program and the Department of Human Services in negotiating contracts with the managed care plans in the county. Close coordination with the State's Services for Children with Handicaps Program will be necessary to serve more than 100 children in North Star School and numerous others in the community who have special health needs. The clinic will work closely with the State MCH Program in its efforts to improve school health services and to expand school-based and school-linked health services.

EVALUATION: The overall health status of children in the Near North community will be monitored annually by KIDSTAT (the health status monitoring program of MDHFS). Data will be obtained through vital records, public assistance information, various city agencies, and special studies. Monitoring of specific objectives will be done through encounter forms and routine enrollment attendance data collected by the school. Monitoring of improved linkages among community health and social service providers will be done through a specially designed referral and tracking form. Progress toward the immunization objectives will be measured by a retrospective study of kindergarten students residing in the community.

EXPERIENCE TO DATE: Clinical and outreach services started on January 7, 1995, with 214 pediatric users and 568 encounters through mid-June. Dental services have been in place throughout the school year, with 420 encounters. Mental health and other social services started in December 1994, with 162 encounters through June. User goals were not met due to a later-than-anticipated opening date for the clinic (75 percent of goal met for students, 7 percent for other children, and 56 percent for home visits). The process of examining all North Star students, as well as marketing services to the community, has started. Pregnancy testing and kindergarten screenings will begin in August 1995. Absences have been reduced by 22 percent over the previous year, and children are up to date on immunizations, with no exclusions from school. Clinical and school staff consult routinely, and health education has been provided in the classrooms. Contracts with most of the medicaid managed care plans have been completed, and reimbursement mechanisms are operational.

Project SEED
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MCHIP
MCJ-258002
10/01/95–09/30/2000
Project Director:
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PROBLEM: Children living in poverty experience a double jeopardy. First, they are more frequently exposed to risks such as medical illness, family stress, and inadequate social support. Second, they suffer more negative consequences of these risks than do children from higher socioeconomic backgrounds. The adverse developmental and behavioral outcomes for children living in poverty include developmental delay, lack of school readiness, and school dysfunction.

Nationally teachers report that one in three kindergartners arrive in school unprepared to learn. Informal reports from the Boston Public School system state that 25 to 30 percent of children entering school are not ready. This is reflected in inadequate reading and language skills, and behavior problems such as limited attention spans and social and interactional skills.

GOALS AND OBJECTIVES: The project goal is to ensure that young children are developmentally and educationally prepared to enter school. To reduce the risk of affective, behavioral, and cognitive delays that contribute to the lack of school readiness, Project SEED will integrate a family-centered, multidisciplinary, culturally competent, developmental practice within a pediatric health care system. The integration of a family advisor into a multidisciplinary team in pediatric primary care will provide the essential link among the family, community, and health care providers. The family advisor will enhance care by adding a home-based component. Over a 5-year period, school readiness skills will increase from 70 to 85 percent in children served by Dimock Community Health Centers pediatric practice.

METHODOLOGY: The project will change the format of the pediatric visit and integrate a multidisciplinary team in targeted health centers. The essential component will be the community link and the home-based services provided by the family advisor. The fundamental premise is that one of the best ways to help children is to help their parents. This two-generation approach acknowledges that child health needs to be integrated with other human services, especially family support services.

EVALUATION: Both the development and implementation of Project SEED will be documented by process evaluation. The evaluation, which will include both qualitative and quantitative data, will describe program components, target population, program staff, and coordination and collaboration with various agencies. Child outcomes will include monitoring of physical growth and nutritional status, and documentation of incidence of episodic illness and hospitalizations. Developmental milestones will be assessed through the administration of standardized instruments. Maternal and family outcomes will include extent of involvement and followthrough in Project SEED; participation in education, literacy, and/or job training programs; use of appropriate health care services; and standardized measures of family functioning, maternal self-esteem, and maternal depression.

Family Friends: Neighborhood Volunteer Corps
Children's Mercy Hospital
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(816) 234-3000

MCHIP
MCJ-298719
10/01/93–09/30/98
Project Director:
Edward Hoffman, M.D.
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PROBLEM: Health problems have been reported in families where substance abuse is a problem. These health problems can occur because of substance abuse during pregnancy, or they may be due to the substance abuser's chaotic lifestyle, in which child abuse and/or neglect are prevalent. In the Kansas City area, more than 40 percent of the infants born at Truman Medical Center, the hospital serving indigent women, tested positive for substances, with 15 percent positive for cocaine. The infant mortality rate in these inner-city areas is more than 15 to 18 per 1,000 births. These rates have evidenced an increase in recent years. Child abuse rates have also escalated recently. The State of Missouri Department of Social Services reported more than 17,000 confirmed cases of child abuse during 1992. A number of factors contribute to this abuse. Women and minorities respond differently to drug treatment than do white males. Mental health problems often accompany substance abuse, and these are correlated with child abuse. The social support networks of these individuals are usually confined to other individuals who use substances. This places the child in more danger of abuse and injury.

GOALS AND OBJECTIVES: Working in collaboration with the health community and grassroots neighborhood groups, the Kansas City Family Friends: Neighborhood Volunteer Corps will implement a comprehensive, family-centered program that will lower the prevalence of disabilities and infant mortality. Specific objectives are to:

1. Develop linkages between the community and health care agencies to strengthen their ability to enhance health outcomes for children in families where substance abuse is a problem;
2. Assist at least 20 families per year (100 total over the project period) with a trained weekly visitor who is a community member;
3. Ensure that the developmental care of each infant, child, and adolescent (100 total over the project period) is maintained through regular visits and immunizations;
4. Decrease by 50 percent the repeat pregnancies of these women within 18 months of delivery, and increase the birthweight of infants born to women who become pregnant during the project period;
5. Decrease the incidence of child abuse in the population as reflected by emergency room/hospital admissions, decrease abuse risk factors of participating families on the Kempe Family Stress Checklist by 70 percent, and increase parenting skill/knowledge on the Adult-Adolescent Parenting Inventory (Bavokil) by 20 percent; and
6. Decrease by 20 percent the needs of these families as reflected by the Family Needs Survey (Bailey and Simeonnson) through collaboration with community agencies.

METHODOLOGY: Collaboration between the health care professionals and the neighborhood groups is fostered through regular meetings and the conduct of this project. Family Friends is a model of trained volunteers who visit families on a regular basis. The families are referred by other ongoing professional programs and pediatricians. Through these friendship visits, a role model is set for the parent, and peer support outside of the drug network is established. The Family Friend encourages developmental visits and assists in making arrangements for these visits. Supplemental programs of The Children's Mercy Hospital will stress health care for the child or adolescent and family, as well as other health issues (e.g., sexually transmitted diseases, adolescent pregnancy). Referral to a network of social agencies by the Family Friend and supporting hospital staff should assist with obtaining needed services and agency support.

EVALUATION: Baseline data on emergency room visits and hospital stays are obtained for each child and adolescent served. The infant mortality rates for the ZIP Codes participating in the project are also obtained. Annual data will document changes. Annual pre/post measurements of immunization records and maintenance of clinic visits will also be performed. The spacing between children and birth outcomes of infants born after participation begins will be compared with the spacing and birth outcomes of previous children. Family needs are assessed using the Family Needs Survey (Bailey and Simeonnson). The Kempe Family Stress Checklist measures family stress. Parenting skill is measured by the Adult-Adolescent Parenting Inventory.

EXPERIENCE TO DATE: The "blending" of the original, traditional Kansas City Family Friends program with the Family Friends: Neighborhood Volunteer Corps has made significant progress in its first 2 years of existence, in spite of some truly difficult challenges. The program was without the full-time stewardship of a program coordinator from December 1994 until May 1995. Despite this 6-month hiatus, the staff of the Social Work and Community Services Department of The Children's Mercy Hospital divided the responsibilities of the program's numerous components and successfully completed its functions. Due to the diligence and determination of the Resource Development Sub-Committee of the Advisory Committee, additional matching program funds were identified, aggressively pursued, and ultimately obtained.

Much progress has been made in the establishment of linkages between potential referral sources and the Family Friends: Neighborhood Volunteer Corps. Volunteer recruitment is being revitalized, and much positive planning is being conducted. With the position of program coordinator recently being filled, a much faster, proactive pace geared toward achieving the program's goals is anticipated.

The original Family Friends program matched senior volunteers with children with chronic illnesses and/or developmental disabilities and their families. The charge and the challenge of the Healthy Tomorrows Family Friends: Neighborhood Volunteer Corps will be to broaden its horizons to include providing friends to families affected by substance abuse. This is a new direction for the program. The program anticipates the possibility of additional training elements for volunteers, and the potential need to broaden its recruitment network.

All of these challenges bring with them the opportunity to serve the many children and families at risk and in need.

Seacoast HealthNet
Seacoast HealthNet
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Portsmouth, NH 03801

MCHIP
MCJ-338004
10/01/95–09/30/2000
Project Director:
Gwendolyn Gladstone, M.D.

PROBLEM: Seacoast HealthNet, a physician-led initiative, has assessed the needs of 22 communities in Southeastern New Hampshire and found that among families with annual incomes below 225 percent of poverty, 29.5 percent of the adults and 20.5 percent of the children do not have health insurance. Based on 1990 census data, the estimated number of low-income uninsured children in the target area would equal 1,443. (This number does not include medicaid enrollees.) A large number of low-income families who have insurance stated that they are at risk of losing their insurance in the next year. Of the children ages 0 to 5 years, over one-fourth who are privately insured could lose their coverage within the next year.

The communities with the largest percent of children under the 200 percent Federal poverty level are also communities that have a higher number of ambulatory care sensitive admissions. The ambulatory care sensitive admissions are conditions (e.g., severe ear, nose, and throat infections; asthma; dehydration) that are decreased if outpatient care is obtained on a timely basis. This rate of ambulatory care sensitive admissions is just slightly less than the overall State rate. When these indicators are combined with data on the number of uninsured children in the community, a clearer picture of the linkage between access to health care and these utilization factors develops. The numbers of workers without health insurance for themselves or their families is projected to continue to increase in the targeted 22 communities.

GOALS AND OBJECTIVES: The project has established the following goals and objectives:

Goal 1: Improve access to health care services by addressing the financial and nonfinancial barriers that exist for the target population.

Objectives:

1. The use of the Seacoast HealthNet physician network will be increased by 250 children, from 300 to 550, creating medical homes for the target population's medically indigent children; and
2. One professional health educator and three lay health educators will be hired.

Goal 2: Increase the involvement of parents in their own education and awareness of child health needs.

Objective: Parents' awareness of their children's health needs in the area of immunizations, appropriate use of the medical care system, basic child development knowledge, parenting skills, and other related health areas will be increased.

Goal 3: Increase the awareness and use of preventive wellness services and activities currently available to low-income families in their communities.

Objectives:

1. Families enrolled will show a 20-percent increase in use of preventive services; and
2. Of the families enrolled in Seacoast HealthNet, 7 percent will be matched with mental health care providers for ongoing mental health therapy.

Goal 4: Reduce the number of admissions due to ambulatory care sensitive and/or injury, and educate physicians in optimal patient management of medical conditions (e.g., asthma, dehydration, diabetic ketoacidosis) that result in frequent hospitalizations.

Objectives:

1. Health education and anticipatory counseling will be provided to all enrolled families regarding each child in the family; and
2. Seacoast HealthNet will sponsor four physician seminars: Asthma Treatment, Oral Rehydration Methods, Injury Prevention, and Violence Prevention in the Teenage Population.

Goal 5: Develop communitywide coordination and integration around health education initiatives.

Objectives:

1. The linkage and coordination process will be increased communitywide by collaborating with Lamprey Health Care to incorporate health education resources into a computerized service; and
2. Seacoast HealthNet will collaborate with the State Health Department's Bureau of Health Promotion and Maternal and Child Health Services in the dissemination of health education materials.

METHODOLOGY: The Healthy Tomorrows initiative will provide staffing to expand existing health education efforts and enhance the family support services currently within Seacoast HealthNet. The Healthy Tomorrows project will fund a full-time health educator and three lay health educators, who will be called Family Health Workers. The professional health educator and three family health workers will work as a team to develop a family-centered project that will bring to the home a comprehensive package of health education services. The health education component will use the family strength model to assist families in identifying their areas of concern and will help each family to address these concerns, by identifying and building on family strengths and maximizing the use of existing medical, mental health, and social services in the area. The health education sessions will offer valuable information for families, as well as a context within which the family can safely explore its own needs and concerns.

EVALUATION: Project analysis and evaluation will be an ongoing, evolving system. In collaboration with the Robert Wood Johnson Foundation component of the overall program, the program data base will generate monthly reports of all recorded service activities. Health data measurements include assessing the (1) number of underserved affected by this program, (2) effect on ambulatory care admissions and injury admissions, and (3) increased access to medical, social, and mental health services in the community.

Healthy Families Santa Fe
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MCHIP
MCJ-358626
10/01/91–09/30/96
Project Director:
Robin Lackey, M.S.W., L.I.S.W.

PROBLEM: On a per capita basis, the incidence of child abuse, neglect, and domestic violence in Santa Fe County is above the national average. Recent data indicate the risk of child abuse and neglect can be reduced significantly if a continuum of supportive educational and therapeutic service is made available to families during the first years after the birth of a child. The most effective child abuse and neglect preventive efforts are home visitation and followup services for families of infants. In *Starting Points* (1994) the Carnegie Corporation addresses the issue of ensuring good health and protection of young children. The article suggests that offering home visitation services to all first-time mothers with newborns is essential. Healthy Families will help reduce child abuse and neglect in Santa Fe County by providing home visitation for first-time parents who are at risk of mistreating their children. Volunteers and paid paraprofessionals will make these home visits.

GOALS AND OBJECTIVES: The program's goals are to reduce significantly the incidence of child abuse and neglect in Santa Fe County and to improve the home environment of families with children.

At the end of the 5-year period the following objectives will have been met:

1. Ninety-five percent of all new mothers in Santa Fe County (1,500 annually) will have received information about early childhood development and the community resources available to them.
2. The average number of first-time parents at risk for abusing their children in Santa Fe County will be determined, so public and private agencies will be better able to allocate money for child abuse and neglect prevention programs.
3. Of parents receiving home visits, 2 percent will have been reported for child abuse and neglect. Based on data from Hawaii's Healthy Start Program, from Breakey and Pratt (1991), and from the Olds (1986) studies, it is estimated that without intervention, at least 20 percent of this high-risk group would be reported for child abuse and neglect.
4. Of parents receiving home visitation, 60 percent will have improved their home environment as measured by Home Observation for Measurement of the Environment (HOME) and will be capable of functioning without the assistance of the home visitor.
5. Of parents receiving home visits, 90 percent will show a statistically significant reduction of changeable risk factors as measured by the Kempe Family Stress Checklist.

METHODOLOGY: First-time mothers who reside in the county and who are referred to the program are interviewed by an early identification worker and given a community resource directory. The risk for child abuse is assessed during the initial visit and the need for intensive participation in the program is determined. Family support workers assist eligible parents in enhancing their parenting and home management skills and encourage positive parent-child relationships. Parents are introduced to community resources that support the family and are encouraged to form their own support network. All services are free of charge.

EVALUATION: The validated Kempe Family Stress Checklist is the pretest and posttest tool. County child abuse or neglect reports are monitored. Individual family support plans are used to monitor family progress. The Revised Denver Prescreening Developmental Questionnaire is administered every 6 months to determine the child's developmental progress. Family support workers discuss individual cases with the project coordinator every 2 weeks.

EXPERIENCE TO DATE: The program has responded to 100 percent of referrals (575) since its inception in 1991. Collaborative services are in place, with a variety of community incentives. Bilingual program brochures, a community resource directory, and early childhood information brochures have been developed.

Helping Enable Indian Children of Albuquerque
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MCHIP
MCJ-358633
10/01/94–09/30/99
Project Director:
Sandra Taft, M.S.

PROBLEM: Urban Indian children residing in Albuquerque, NM, who have disabilities are not receiving the full continuum of care they require to promote optimal health and functional ability. These children are not being adequately identified to the health care system, are not effectively accessing available services, and are not fully utilizing health care and related social support services. For urban Indian children with special needs, access to services is impeded by (1) a lack of recognition of the needs of urban Indians; (2) the mobile nature of the population; (3) differences between reservation-based and urban health care delivery systems; (4) a lack of understanding of the health care system on the part of families; (5) a lack of awareness about urban Indians on the part of providers; (6) a frequent lack of basic services and resources for families, such as adequate housing, transportation, and child care; and (7) a lack of outreach. A year-long Census and Needs Assessment project provided baseline data, defined the target population, provided information about the interaction between service providers and urban Indian families, and provided the impetus for this project.

GOALS AND OBJECTIVES: The project has two major goals:

1. Improve access to and utilization of health care and related resources by urban Indian children and their families; improve the health care system that serves these children by facilitating access and promoting utilization by client families.
2. Improve the health status, functional ability, and developmental capability of urban Indian children with limiting conditions and special needs. This long-term goal, relevant to *Healthy People 2000* objectives, is a health status goal that is directly related to problems inherent in the current health system (i.e., inadequate access to and utilization of services).

Program objectives include:

1. Identifying children who need services;
2. Improving service coordination;
3. Providing families with case management and advocacy skills;
4. Helping families to negotiate the urban health care system;
5. Fostering parent-provider partnerships;
6. Increasing the ability of agencies to serve and assist Indian families; and
7. Creating a culturally appropriate linkage between urban Indian families with disabled children and the full expanse of local service providers.

Outcome objectives include:

1. A formalized plan for creative outreach, home visitation, and program participation for urban Indian children with special needs and their families;
2. The ability of all client families served to identify a medical home;
3. An Individualized Family Service Plan (IFSP) for all client families;

4. Completion of at least 12 hours of individualized advocacy and case management training for 75 percent of client families;

5. Acknowledged competency in advocacy and case management training for 75 percent of client families completing 12 hours of training; and

6. Achievement of formal written agreements of cooperation with 80 percent of key agencies serving urban Indians.

METHODOLOGY: The program approach is designed to address the needs of urban Indian children with disabilities and ultimately to help increase their physical, social, and emotional health and functional ability. The approach comprises five components:

1. Creative outreach to provide active and innovative ways to locate, recruit, and enroll clients;

2. Case management to ensure that clients with complex multiple problems and disabilities receive all the services they need in a timely and appropriate manner;

3. Family empowerment through skills building to draw on the natural strengths and abilities of families;

4. Parent-provider partnerships to reduce cultural and jurisdictional barriers, provide common ground for communication, and provide a comfortable atmosphere for the family; and

5. Community awareness to increase collaboration with State and local providers, coordinate activities with service agencies, and increase communication with the provider community and with the urban Indian community.

The target population for the project is composed of three segments of the Albuquerque population: (1) Children with special health needs, (2) their families, and (3) service providers. This program will provide case management activities for the child as well as support services, education, assistance, and training for the family. Local providers will be the focus of client services coordination, cultural awareness efforts, and informational activities about the urban Indian population in general and about urban Indian children with special needs. Program activities include (1) outreach and case finding, (2) linkage to services and services coordination, (3) establishment of a medical home, (4) development of IFSPs, (5) training and education for families, and (6) provider outreach. Implementation of the client family IFSPs will be facilitated by screening, assessment, referral, tracking, training, and data management. Client families will progress through five defined levels of service. Services will be provided at various field sites throughout the city to make the program accessible to a majority of the target population. Data collection and data management will provide documentation of program activities and progress and will provide information to the project's advisory board and to funding agencies. This program is a joint venture between several Albuquerque-area service providers. The program will be developed and housed through the All Indian Pueblo Council, Inc., Speech and Hearing Program and will serve the needs of disabled urban Indian children from all tribes. Project partners include State of New Mexico Children's Medical Services; Parents Reaching Out, a nonprofit organization of parents and professionals; local pediatricians from the U.S. Public Health Service (PHS) Indian Hospital and the Lovelace Medical Center; and Indian parents of children with special needs.

EVALUATION: Program evaluation will be performed through the periodic measurement of outcome objectives, client progress, client satisfaction, and program objectives. Operational and management data will be collected and analyzed. Family interviews and provider surveys will be conducted periodically. A formative evaluation of the target population, program services, and client family progress will be conducted at 6 months. A summative evaluation of program objectives and program performance will be conducted at 12 months. Monthly, quarterly, and annual progress, statistical, and status reports will be furnished to the advisory board and to the funding agency.

EXPERIENCE TO DATE: Outreach to potential clients has included referrals from local agencies and PHS Indian Hospital pediatricians. The IHS Children's Special Needs Register is also being used to locate children within the system. A variety of methods are used to give information to the general public on a regular basis. Service coordination has been provided for 29 families to date. This has involved assisting families in locating and accessing services, attending Individualized Education Program (IEP) meetings and medical appointments, following up on referrals and appointments, and providing advocacy for children who need housing and emergency assistance. Program families are feeling more confident in accessing services and learning about the law as it pertains to children with disabilities. These are the tools being used to advocate for their child. Community awareness began by collaborating with local agencies, facilitating communication, and increasing awareness of the needs of urban Indian families. Formal training for providers is scheduled for later this year.

Puentes Program (Taos Teen Parent Support Program)
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MCHIP
MCJ-358631
10/01/94–09/30/99
Project Director:
Nicola Baptiste

PROBLEM: The general health status problem in Taos County, New Mexico, is poverty. The economic and demographic changes of the last two decades have led to a significant increase in the proportion of adolescents who have lived in poverty for prolonged periods. The specific health status problem in Taos County is the increasing rate of births to girls 15–19 years old.

GOALS AND OBJECTIVES: The Taos Teen Parent Support Program (TPSP) has the following goals and associated objectives:

1. Provide the means for adolescent parents to develop improved health and safety practices for themselves and their babies.
   a. By 1996, an accessible, comprehensive, coordinated services system will be established for adolescent parents;
   b. By 1996, at least 75 percent of program participants will have breastfed their babies for at least 2 weeks;
   c. By 1996, at least 50 percent of program participants will have prolonged breastfeeding their babies for at least 6 months;
   d. By 1996, at least 85 percent of program participants will have received their full schedule of well-baby visits, including immunizations, as defined by American Academy of Pediatrics (AAP) recommendations;
   e. By 1996, the majority of program participants will have responded adequately to their children's injuries and/or illnesses;
   f. By 1996 at least 66 percent of the program participants will not have a repeat pregnancy before age 19; and
   g. By September 30, 1995, a component will be developed to validate and document culturally traditional and developmentally appropriate methods of infant health care with program participants.
2. Provide opportunities for support for adolescent parents in developing positive child-rearing practices.
   a. By September 30, 1995, a component will be established to validate and document culturally traditional and developmentally appropriate methods of child rearing with program participants;
   b. By 1996, the rate of reported cases of child abuse and/or neglect in program participant families will be not more than 5 percent; and
   c. By the time of their graduation from TPSP, participants' interaction with their children will show evidence of increased and integrated knowledge of child care, child development, and appropriate developmental expectations for their babies.
3. Increase possibilities of long-term self-sufficiency for adolescent parents.
   a. By 1996, at least 85 percent of program participants will graduate from high school or obtain their General Equivalency Diploma (GED) by the time they are 20 years old;

b. By the time of their graduation from TPSP, participants will show evidence of increased understanding of job possibilities and requirements for specific training and employment opportunities; and

c. By the time of their graduation from TPSP, participants will show evidence of having set appropriate and realistic short-term and long-term goals for their future education, childbearing, marriage, housing, and employment.

METHODOLOGY: TPSP will identify first-time pregnant adolescents through referrals from various entities in the community. An intake process will be done by the program coordinator in the first appointment with the TPSP participant; a care coordination plan will be developed from this process. The program will also encourage intergenerational support and community involvement through documentation and oral transmission of traditional Hispanic and Native American health and parenting practices. The core of the program will be two weekly group meetings with the project coordinator and the part-time paraprofessional group facilitator. These groups will have three functions: (1) To provide direct services in the form of well-baby Early and Periodic Screening, Diagnostic and Treatment visits and immunizations for babies of the participants; (2) to provide education and information; and (3) to provide support and encouragement for the adolescent parent participants. Supplementing the group will be a limited home visitation program to build confidence and intimacy between staff and the TPSP participants and to monitor outcomes.

EVALUATION: A data analyst will (1) review model instruments and data collection software programs, consult with the State MCH epidemiologist, consult with the MCH and AAP technical assistance units, and discuss specific outcome data needs with Taos MCH Council members and providers; (2) develop the evaluation process and schedules, including pretests and posttests, specific monitoring instruments, and collection of data from existing sources; and (3) implement the evaluation process and perform data analysis. In addition to these evaluation measures, TPSP will agree to participate in independent evaluation by the Healthy Tomorrows Partnership for Children Program or a designee.

EXPERIENCE TO DATE: Puentes staff were hired and began working on October 1, 1994. The decision was made to split the full-time funded position into two half-time positions, a Puentes counselor and a Puentes case manager. Staff performed the first client intake on October 3, 1994. There are currently 26 adolescent mothers on our client list; of these, 16 are in a "primary" category and 10 are in a "secondary" category. These categories reflect the level of involvement with the Puentes Program and were created to facilitate evaluation based on our objectives. Of the 26 participants, 69 percent are Hispanic, 19 percent are Native American, and 12 percent are Anglo. A total of 61.5 percent of the participants are age 16 and under; 38.5 percent are over 16, with the largest single group (35 percent) being exactly 16. Six percent of participants have a 1-year age difference between them and their baby's father; 11 percent have greater than a 5-year age difference. The largest single group (44 percent) has a 2-year age difference between them and their baby's father.

Puentes staff, along with the Community Wellness Council and our Puentes Advisory Council, have identified five major program areas to be implemented over the first and second years of funding. These five areas are: Support group, peer counseling, home visitation, male involvement, and cultural documentation project. The support group and peer counseling components are fully operational. The home visitation component is partially operational, and some plans and inroads have been made in the male involvement and cultural documentation project areas.

The primary obstacle we have encountered in trying to fully meet our objectives has been the large amount of staff time devoted to case management and crisis intervention for Puentes participants. The most helpful and successful aspects of the program have been the incredible success of our peer counseling component and the high level of cooperation and collaboration Puentes staff have established with local health professionals and service providers.

Pediatric Comprehensive Asthma Management Program (PedCAMP)
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MCHIP
MCJ-368214
10/01/92–09/30/97
Project Director:
David J. Valacer, M.D.

PROBLEM: During the 1980s nationwide hospitalization rates increased 4.5 percent annually for asthmatics less than 17 years old, while admission rates for other respiratory diseases declined (unrelated to a shift in diagnostic coding). New York City, with less than 3 percent of the nation's population, accounted for approximately 6 percent of all asthma hospitalizations. Race is not a cause of the observed difference, but poverty is. Among New York City neighborhoods there is a 16-fold difference in asthma hospitalizations, with the highest rates in the poorest areas.

The Women and Children's Health Center is a State-funded primary care center in a Health Crisis Zone of western Queens where the highest hospitalization rates in the city have occurred for conditions sensitive for ambulatory care. This area has the highest admission rates for pediatric asthma/bronchitis in Queens. The Pediatric Comprehensive Asthma Management Program (PedCAMP) was established to address this health status problem of increased pediatric asthma hospitalizations.

The three major contributing factors identified for the problems currently observed are (1) inadequate access to specialty care for asthma and related conditions; (2) inadequate understanding and counterproductive attitudes about asthma, resulting in poor compliance; and (3) increased target population exposure to environmental allergens and/or irritants.

GOALS AND OBJECTIVES: The primary outcome goal of this project is to reduce the overall asthma/bronchitis hospitalization rates by 80 percent for children enrolled in this program over the first 36 months of enrollment and to maintain this lower level throughout enrollment. The secondary outcome goals, to be met within the same timeframe, are to (1) reduce emergency room visits by 50 percent; (2) normalize pulmonary function; and (3) reduce school absenteeism due to asthma.

METHODOLOGY: In response to the health systems problem of inadequate access to specialty care, PedCAMP began providing onsite comprehensive evaluation and treatment for asthmatic children beginning in January 1993. Through two weekly outpatient sessions, physicians, nurses, and a social worker (1) provide neighborhood access to subspecialty evaluation, education, and treatment for asthma; (2) coordinate home and school care; and (3) facilitate procurement of prescribed asthma and allergy interventions for children with chronic moderate-to-severe asthma.

To accommodate our increasing patient demand, we will expand to two sessions per week beginning in July 1993 (our seventh month of onsite clinical activity). We are adding two new physician providers to our program in year 1, and the percent effort of the specialist nurse and social worker will increase commensurate with our increased patient care sessions. Our patient education outreach program brings PedCAMP providers into neighborhood schools to present asthma teaching seminars to parents and students. Our onsite patient education programs focus on improving medication compliance and allergen avoidance; in year 2 these programs will be expanded to include elimination of environmental tobacco smoke exposure.

EVALUATION: We track objective data on hospitalizations, emergency room visits, pulmonary function, and school attendance at each visit and compare these data with pre-enrollment levels. Subjective assessments of compliance and self-management skills are made at each visit by review of interim history and physical examination. As patients improve and self-management improves, program visits are scheduled less frequently until patients are returned to primary care management with only quarterly followup visits to our program.

We review success in community and patient impact and data collection in regular staff and community advisory board meetings. We specifically track patient compliance in keeping scheduled appointments. We use follow-through on scheduled tests and appointments as a reflection of patient satisfaction with our clinical program. We maintain a patient log book for data entry at each visit regarding the clinical parameters we are tracking. Quarterly data review is used to identify problems with data retrieval.

EXPERIENCE TO DATE: In 1994 we had 1,083 patient visits, an increase of 320 visits over the previous year. Seventy-nine asthmatic children are currently in our long-term followup program. For clients enrolled for at least 1 year, there was a reduction of 0.9 hospitalizations per child and a reduction of 7.25 emergency room visits per child compared to the 24-month period prior to enrollment. For clients enrolled for at least 2 years, we observed parallel 0.4 and 3.2 per child reductions. It is difficult to formally assess school attendance, but more than 80 percent of patients' parents report fewer school absences after enrollment. Our neighborhood school outreach program has increased community exposure to and public awareness of asthma. We have a high school externship program and have had four internship rotations in the past 18 months in our other health care programs. This externship allows students to experience community-based health care, and two of our students plan to seek postgraduate training in allied health fields.

Mental Health Treatment for Sexually Abused Children

Duke University
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MCHIP
MCJ-378405
10/01/92–09/30/97
Project Director:
Thomas E. Frothingham, M.D.

PROBLEM: The mental health and behavior of sexually abused children often are poor, lasting into adult life. In the six-county project area in north central North Carolina, access to appropriate mental health services fails for more than half of the children identified (diagnosed) by the Child Protection Team as suffering from child sexual abuse. Current standards dictate that sexually abused children are especially in need of mental health services.

GOALS AND OBJECTIVES: This project will improve function of sexually abused children by improving access for these children and their families to appropriate mental health services. Measurable specific objectives are as follows: (1) Identification of family-specific reasons for and relative importance of factors causing failure of access; (2) improved rate of access to and utilization of appropriate mental health services for identified children and their families; and (3) improved mental health and behavior of sexually abused children.

METHODOLOGY: A three-part methodology will be used: (1) A brief questionnaire will be developed with which to determine for each family the nature and relative importance of barriers to access to appropriate mental health services. (2) On the basis of this information and general information from each client's data base, family-specific strategies will be implemented to achieve access. (3) Evidence for improvement in mental health status will derive from periodic behavioral and mental health assessments.

EVALUATION: Each child will be tracked with the aid of a computerized data base. Tracking comprises periodic queries to the mental health service to which the child has been referred. Queries comprise questions about the degree to which the child has accessed services and about behavior and mental health status. Contact will be made with families and involved professionals where access has failed, in order to learn the reasons and to promote access.

Access will be measured in terms of the proportion of referred children attending the mental health services to which they were referred. Mental health and behavioral status will be measured by periodic screening questionnaires and global mental health assessments. Periodic gathering of data on these measures will provide evidence of the success of the project.

EXPERIENCE TO DATE: Baseline data have confirmed our suspicion that sexually abused children fail to receive mental health services at least one-half of the time. We have come to believe that a caretaker committed to believing that the child was indeed abused, to helping to protect the child, and to being involved in the therapeutic plan is essential to success. When there is no committed caretaker, we find the situation to be gloomy indeed. Multiagency collaboration is essential and requires a turf-neutral, user-friendly, convenient, free-standing facility in which professionals can truly work together from the beginning of a case. We have therefore moved on to developing such a place, with the enthusiasm and financial backing of three local universities and public and private groups who are mandated and/or committed to better ways of dealing with child abuse, the most prevalent and serious health problem of our children.

Collaborations for Healthier Children
Good Samaritan Medical Center
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MCHIP
MCJ-398528
10/01/91–09/30/96
Project Director:
Debbie Wilson, R.N.

PROBLEM: Comprehensive health care services for infants and children are often unobtainable by the indigent and working poor populations in southeastern Ohio. Increasing unemployment, alcohol and drug abuse, and the incidence of adolescent parents exceeding the national and State averages all have impact on clients' ability to access primary health care for their children. Reluctance of private physicians to participate as primary providers for this population further complicates a system already lacking continuity of care. Fragmented care, inappropriate use of emergency rooms, and medical neglect are too often the results of not having a medical home.

GOALS AND OBJECTIVES: Collaborations for Healthier Children focuses on the timely delivery of health care services to children residing in an underserved rural six-county area. Project goals are as follows:

1. Improve access to health care for all indigent children ages 0–12 in our six-county service area;
2. Improve the coordination, quality, and continuity of care through the delivery of medical, nursing, education, and social services to the target population;
3. Increase availability of support services to the adolescent parent; and
4. Identify high-risk infants and children, providing necessary referral and followup for these groups.

METHODOLOGY: During its first year, Collaborations for Healthier Children developed its health care team, composed of eight area physicians, three pediatric nurses, one social worker, one pediatric nurse-practitioner, and support staff. Comprehensive health care is provided by team members. Preventive health care, education, and anticipatory guidance are paramount, having impact on the quality of life not only for the child but for the entire family.

Children in need of a medical home are identified by the inpatient obstetric and pediatric nurses; Good Samaritan's prenatal clinic; area physicians; the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); and the Physicians' Referral Service. Attempts are made to place high-risk children with a private physician.

EVALUATION: Project activities are monitored through statistical information as well as other methods. Monthly statistics are tabulated to monitor clinic productivity for the physicians and the nursing staff. These statistics also monitor the number of children who receive well-child care or ill-child care.

The advisory board consists of representatives from six county health departments, clinic physicians, three parent representatives, and the clinic nursing staff. The board has been established to monitor the progress of the Children's Health Center in meeting its stated goals and objectives.

Information from patient surveys is shared with the nursing and support staff for evaluation, recommendations, and action as needed. Team progress toward meeting project goals is discussed and reviewed at monthly nursing staff meetings.

Chart review is used as a method of evaluating the coordination, quality, and continuity of care. Access to health care is also monitored through chart review. The charts of children of adolescent parents are evaluated to ensure that needed support services are provided.

EXPERIENCE TO DATE: The Collaborations for Healthier Children program opened in December 1991, the advisory board having been established the month before. Referrals were initially received from local hospital nurseries and physicians and were limited to newborns for a short period of time. As growth was slow, the limit was quickly expanded to include children through age 12.

The number of children receiving care has steadily increased, and several have been able to access care through private doctors. Newborn referrals from physicians have also increased. The pediatric nurse-practitioner has expanded her services to include some minor ill-child care. Parenting classes have been provided, but specialized one-to-one education has proven more effective. With the advent of 24-hour hospital discharge of newborns, additional visits are needed to address hyperbilirubinemia and newborn screening.

Healthy Tomorrows/Child and Family Health Services Pediatric Tracking Program
Cincinnati Health Department
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MCHIP
MCJ-398511
10/01/92–09/30/97
Project Director:
Edward F. Donovan, M.D.

PROBLEM: Among 850 Cincinnati women who delivered following suboptimal prenatal care since October 1990, utilization of preventive child services and child health outcomes are poor. Infant mortality for this group of primarily African-American, inner-city children is 50 per 1,000 live births. More than 50 percent of these children do not keep their first well-child appointment, many are significantly underimmunized, and the emergency room is used frequently and inappropriately. Approximately 25 percent are born with low birthweight, and the associated health care costs are staggering.

GOALS AND OBJECTIVES: The goals of the Cincinnati Healthy Tomorrows program are to (1) improve health and early educational outcome for inner-city infants born to women with suboptimal prenatal care, and (2) improve the outcome of subsequent pregnancies of index families. Specific aims are to:

1. Increase appropriate utilization of preventive children's services in the first 3 years of life;
2. Reduce infant mortality, primarily by reducing the low birthweight rate;
3. Reduce inappropriate utilization of the emergency department as well as rehospitalization for preventable childhood illnesses; and
4. Reduce the cost of care for children and their mothers by implementing specific preventive strategies.

METHODOLOGY: A community-based, community-managed program employs and trains outreach workers who reside in the same neighborhoods as the identified at-risk families. Using a case management model, community outreach workers will identify family-specific barriers, empower families to overcome these barriers, serve as a liaison between families and preventive services providers, and work with a Community Advisory Board to identify and reduce other communitywide barriers.

EVALUATION: The project is nested within an ongoing longitudinal cohort outcomes analysis begun in 1990. Women with fewer than two prenatal visits who deliver at either of two Cincinnati hospitals and their children are enrolled. Children are tracked to age 3 using computer-based, mailed, and personal contacts with all Cincinnati health providers who care for medicaid-eligible children and with the Bureau of Vital Statistics. Information is collected regarding receipt of well-child care (American Academy of Pediatrics recommendations), emergency department and inpatient utilization, low birthweight, infant mortality, subsequent pregnancy outcome, and cost of care.

Families in the longitudinal outcomes analysis that receive community outreach worker services will be compared to those that do not in the areas of receipt of preventive services, incidence of preventable illnesses and injuries, infant mortality rate, rate of prematurity in subsequent pregnancies, and cost of care. We now enroll approximately 250 children per year, of whom 40 to 60 will receive community outreach worker services.

EXPERIENCE TO DATE: Two community outreach workers have been hired and a training and supervision program is in place. A 15-member Community Advisory Board provides input on program content and writes and modifies the community outreach worker job descriptions. Families in the target neighborhoods are assigned to community outreach workers as caseloads permit. We anticipate that data will be available within the next year to evaluate the impact of this program on outcomes in early infancy.

The program is now located in the West End Health Center, a longstanding neighborhood health center with great support and respect in the community. We are seeking support to expand eligibility on a population-based method allowing enrollment independent of birth hospital. In addition to our brochure, a quarterly *Healthy Tomorrows Newsletter* is now published.

Toledo Healthy Tomorrows
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MCHIP
MCJ-398536
10/01/94–09/30/99
Project Director:
Bernard J. Cullen, M.D.

PROBLEM: Maltreatment of children constitutes a major social and medical problem in Ohio. Although child abuse occurs in all families regardless of structure or income, children born to adolescents are particularly vulnerable to abuse. Their parents often lack the emotional maturity and the personal and social support necessary to properly care for their infants.

In 1992, Lucas County Children Services of northwestern Ohio investigated 4,232 referrals, an increase of 18.8 percent over 1987. Compared with Ohio's eight largest counties, Lucas County ranks third in referral rates. In 1992, 35 of every 1,000 children were referred to Lucas County Children Services for possible abuse or neglect. Improving the caregiving skills of adolescents is of paramount concern because Lucas County has the highest unmarried adolescent pregnancy rate and the highest repeat birth rate by adolescents in the State. More and more adolescents in Lucas County are having children, and fewer and fewer have partners with whom they can share parenting responsibilities. As a result, a generation of children is being reared by undereducated and emotionally immature mothers who often lack the parenting skills and personal support system necessary to ensure their children's well-being.

GOALS AND OBJECTIVES: The goal of the project is to reduce the incidence of child abuse and neglect among children of adolescent families participating in the program. The outcome objective is to reduce the need for children participating in the project to be referred to Lucas County Children Services for possible abuse or neglect, such that close to 0 percent of participants require referral to Lucas County Children Services during the project period. The project's impact objectives are:

1. Improvement in parent-child interaction skills shown by 80 percent of participating families, as measured by the Home Observation Measurement of the Environment (HOME);
2. At least nine well-baby visits by 70 percent of children served by this program by age 24 months; and
3. Completion of age-appropriate immunization schedules by 75 percent of children participating in this program by age 2.

METHODOLOGY: The Toledo Hospital, together with a coalition of parents, pediatricians, and representatives of the Maternal and Child Health Bureau of the Ohio Department of Health and the Toledo Department of Health, designed and developed Toledo Healthy Tomorrows. Toledo Healthy Tomorrows will serve about 80 targeted adolescent families over the 5-year project period. The project will rely on the services of lay persons and professionals. Each participating family will be visited by one of four specially trained Visiting Moms who will be hired by The Toledo Hospital on a part-time basis. The Visiting Moms will initiate contact with the adolescents during their seventh or eighth month of pregnancy and will make at least two home visits before delivery.

Following delivery, the families will be visited every week for 6 weeks, every 2 weeks from 2 to 4 months, every 3 weeks from 4 to 14 months, every 4 weeks from 14 to 20 months, and every 6 weeks from 20 to 24 months. Family caseloads will never exceed 21, averaging about 12 families per month over the 5-year period. During the home visits, the Visiting Moms will counsel, support, assist, and educate the parents and link them with health and social service agencies in the community.

Visiting Moms will receive extensive training, including the Nursing Child Assessment Satellite Training and monthly inservice training regarding child health, development, and abuse prevention. So that the services will be provided in a sensitive and culturally relevant manner, all Visiting Moms will receive intensive multicultural competency training.

Nurses will also visit the families (and an equivalent comparison group of families) when the children are 1 month, 6 months, 1 year, and 2 years old. During these visits the nurses will (1) assess the child's health status, (2) answer questions about child health issues, and (3) administer the HOME inventory.

EVALUATION: To assess the effectiveness of Toledo Healthy Tomorrows, participating families will be compared with an equivalent group of adolescent families using two measures of parenting skills: (1) The HOME inventory, and (2) reported incidence of child abuse or neglect that can be confirmed by Lucas County Children Services. Toledo Healthy Tomorrows will also monitor the immunization rates of children participating in the project and the frequency and appropriateness of well-baby visits. It is anticipated that families that have been assigned a Visiting Mom will (1) score higher on the HOME inventory, (2) have less reported incidence of child abuse and neglect, (3) have better child immunization rates, and (4) bring their children to a pediatrician for well-child visits more often than families in the comparison group.

EXPERIENCE TO DATE: Sixteen adolescent mothers, ranging in age from 14 to 19 years, are enrolled in Toledo Healthy Tomorrows. Seven are African American, six are Caucasian, and three are Hispanic. All but one are unmarried. Three teens are living with the father of their baby, seven teens are living with their parents, one teen is living with her grandmother, and five teens are living with people other than their immediate family or the baby's father's immediate family. Only one teen has dropped out of the program.

Twelve teens have delivered. Six of the infants are male and six are female; four are Caucasian, four are African American, three are Hispanic, and one is mixed race. The infants are in good health and living with their mothers. All but one baby (no longer in the program) are up to date on well-baby visits. Three babies are not up to date on immunizations. One baby is no longer in the program, and the Visiting Moms are working with the parents of the other two children to schedule appointments.

Kids' Clinic
Eugene School District 4J
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MCHIP
MCJ-418017
10/01/93–09/30/98
Project Director:
Pamela Tibbitts, B.S.N.

PROBLEM: Many students from kindergarten through eighth grade in Eugene School District 4J have no medical care other than visits to the emergency room at Sacred Heart General Hospital. Many students are not immunized for common childhood diseases. Parents of younger indigent students who take care of medical needs at the emergency room frequently wait too long to seek care so that serious medical conditions result. Although the school district instituted school-based health clinics in two of its four high schools 2 years ago, younger students also need access to care.

An influx of Hispanic students into the district in recent years has highlighted the need of this group to have better access to health care. Hispanics often do not use a preventive approach to health care, due to economic constraints and cultural barriers; they need an opportunity to see the positive effects of preventive care. Although 51 local physicians, Sacred Heart Hospital, local laboratories, and other health services are eager to supply free care to indigent students, these students lack the access to services that could be provided by referrals from school-based health clinic staff.

GOALS AND OBJECTIVES: The 5-year Kids' Clinic project has the following goals and objectives:

1. Provide indigent kindergarten through eighth-grade students in the district with a medical home by:
    a. Extending preventive-maintenance medical care to indigent students in grades kindergarten through eight by enrolling 35 new students by 1998, thus providing continuity of care from a familiar health professional; and
    b. Ensuring that 10 percent of the students seen at the school-based clinics are in the target population.
2. Ensure that kindergarten through eighth-grade students will no longer be without medical care equal to that of insured students or students receiving medicaid benefits by:
    a. Ensuring that by 1993, all target population students enrolled in school clinic care will have access to previously unattainable services, including free physician laboratory services and hospital care when treatment is beyond the expertise of the nurse practitioner; and
    b. Ensuring that by 1998, 25 percent of referrals from the school clinics to private physicians, Sacred Heart Hospital, and other diagnostic agencies for free extended care are for students from the target population.
3. Reduce emergency room visits for childhood illnesses (e.g., ear infections, strep throat) through school-based clinic treatment services delivered to indigent kindergarten through eighth-grade students in the Eugene School District by:
    a. Increasing the ratio of targeted population students seen by the clinic compared to the ratio of targeted population seen by the emergency room for visits associated with acute childhood illnesses and chronic disorders (e.g., infections or asthma); and
    b. By 1998, decreasing by 10 percent the emergency room visits for treatment of childhood diseases and chronic disorders by Eugene School District students in the target population who have no insurance, medicaid coverage, or ability to pay.

METHODOLOGY: Eligible students and their families will learn about district school-based clinic services through marketing and referral from school nurses. Families will visit the clinic together, and transportation will be provided if needed. A nurse practitioner will see students and their families, referring them as needed to Sacred Heart Hospital or a network of physicians, laboratories, and other service providers. Hispanic families will see bilingual staff and receive materials in Spanish, and staff will receive heightened cultural awareness training from the district community minority liaison.

EVALUATION: The school-based health clinics are monitored by an advisory health council that will also conduct process evaluation for this project. Objectives of the project are stated in measurable terms to facilitate project evaluation. Clinic staff and school nurses will collect the data necessary to determine that progress is being made toward objectives. An evaluation plan for data analysis and summative evaluation will be developed and carried out by the Oregon Research Institute, a nationally recognized research center in Eugene.

COFANI Medical Home of Coamo
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MCHIP
MCJ-728003
10/01/95–09/30/2000
Project Director:
Luisa I. Alvarado, M.D.

PROBLEM: In Coamo, Puerto Rico, children with special needs lack primary preventive health services by qualified pediatricians; have poor access to diagnosis, consultation, and treatment services by specialists; and lack the coordination and followup needed to manage their complicated medical and developmental problems.

GOALS AND OBJECTIVES: The project goals are to:

1. Develop a family-centered, medical home project to provide quality pediatric primary care services, referrals, followups, and continuity of care to children with special needs;
2. Provide developmental and behavioral consultation services onsite to children with undiagnosed, underserved, and complicated developmental and behavioral problems;
3. Collaborate with other concerned agencies and organizations in early identification and treatment of children with disabilities, developmental delay, or other complicated medical problems; and
4. Educate other professionals in the field to improve the quality and timing of the services.

METHODOLOGY: To improve access to quality preventive and specialized health care services, a medical home clinical setting will provide pediatric examinations, immunization services, referrals, and followups to children with special needs. A clinical setting for developmental and behavioral consults will be developed to improve access to these services for children with developmental delays and complicated developmental or behavioral disorders. Services will be provided by developing an individualized service plan with baseline health status data, family participation, and evaluations of outcome. To improve quality and access to services, the project will collaborate on meetings and educational activities with agencies providing services to children with special needs.

EVALUATION: Achievement of outcome objectives and changes in the specific health problem will be assessed by using several strategies. To ensure continuous vigilance of adequate use of resources, the clinic secretary will keep a daily record of services provided.

To ensure coordination efforts are in place, a record will be kept of (1) services rendered by other organizations including government agencies and programs and community agencies, (2) meetings, and (3) education and outreach activities. Coordination efforts with government agencies and other programs will be recorded for future program evaluation efforts and comparison purposes.

For each child with special needs, basic health status indicators will be recorded—with the contributions of the pediatrician, family, and other project staff as indicated—in the individualized service plan. The plan will be updated on followup visits to include progress as the result of interventions. The parents and pediatrician will discuss and formulate the outcomes expected and evaluate the results in the light of their expectations. At the end of the first grant year, the individualized service plan evaluation will serve as the principal instrument to evaluate achievement of outcome objectives and changes towards the resolution of the specific health problem.

Proyecto Lacta
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MCHIP
MCJ-728001
10/01/95–09/30/2000
Project Director:
Jeanette Panchula, R.N., I.B.C.L.C.

PROBLEM: The number of children totally breastfed at the age of 1 month decreased to less than 4.5 percent for children born in both public and private hospitals in Puerto Rico from 1946 to 1982. Current rates have not been studied, but it is clear that without strong pro-breastfeeding programs Puerto Rico will not reach the *Healthy People 2000* objectives of 75 percent breastfeeding in the early postpartum period and 50 percent breastfeeding for 5–6 months. The Joint WHO-UNICEF statement of 1989 directs maternity services to create a program that includes protection, promotion, and support to increase breastfeeding rates. If any one aspect is not addressed, the breastfeeding family will not receive the assistance it requires. Promotion includes educating the population directly and through health care providers who have received education related to breastfeeding of at least 15 hours beyond that provided by schools of medicine or nursing, including one-on-one role modeling. Protection includes providing adequate breastfeeding assistance at and after birth. Support requires having specialized professionals and lay persons who can assist the family. Currently no program in Puerto Rico addresses these issues.

GOALS AND OBJECTIVES: The goals of this project are to:

1. Increase the breastfeeding rates in the low-income families of the San Juan Health District by at least 100 percent over the measured baseline; and
2. Improve the health status, functional ability, and developmental capability of these medically indigent infants.

The project objectives include:

1. Private and public sector populations will be studied to establish a formalized baseline statistic of breastfeeding rates;
2. Health professionals in nine sites will be educated on basic assessment skills and ways to promote and support breastfeeding; and
3. Mother-infant pairs with breastfeeding difficulties will be provided affordable expert breastfeeding assessment and assistance at a lactation clinic.

Outcome objectives include:

1. A formalized baseline statistic will be obtained;
2. Ninety percent of health professionals identified as the key prenatal educators (educator or prenatal nurse) at each of nine centers will be educated on ways to promote and support breastfeeding;
3. Fifty percent (in the first grant year) and 75 percent (in subsequent years) of other health professionals (nurses and doctors) participating in postnatal mother and infant care at the nine centers will be educated on basic assessment skills and ways to promote and support breastfeeding;
4. Ninety percent of those educated in objectives 2 and 3 will have self-acknowledged competency and be able to correctly answer 80 percent of the posttest questionnaire in areas of breastfeeding promotion, support, and assessment;

5. A minimum of 20 percent (in the first grant year) and 30 percent (in subsequent years) of patients seen in the lactation clinic will be medically indigent;
6. A minimum of 100 mother-infant pairs with breastfeeding difficulties will be served in the lactation clinic during its first year of operation; and
7. During project years 2 and 3, 20 peer counselors will be trained.

METHODOLOGY: The baseline will be established by contacting a representative sampling of women who have delivered in one public or one private hospital and asking them questions related to their infant-feeding choice and the support they received. An experienced lactation consultant will use literature, one-on-one, and role-modeling methods to educate health professionals from the nine sites on how to provide breastfeeding education and support to their clients. Direct breastfeeding support will be provided by creating a lactation clinic for mother-baby pairs with breastfeeding difficulties so they can be evaluated by pediatricians and lactation consultants or breastfeeding educators. They will be taught how to overcome their problems and will be assisted in obtaining the items necessary to help the mother breastfeed her infant.

EVALUATION: Program evaluation will be primarily through the periodic measurement of outcome objectives. A report on the baseline statistics will be made available to the local departments of health and to anyone else needing this information. In this way, it may be used by others who also want to increase breastfeeding rates. Preeducation and posteducation tests will be given to quantify the effectiveness of the education. Health care educators will be asked for evaluation reports during and after the project to identify effective and ineffective strategies. Patient record evaluations and postcontact interviews will be used to identify the effectiveness of the clinic and to determine the percentage of patients referred from the public health sector. A summative evaluation of program objectives and program performance will be conducted at 12 months. Quarterly and annual progress, statistical, and status reports will be furnished to the board of directors and the funding agency.

Foster Children's Assessment, Referral, and Care Coordination Project

Rhode Island Public Health Foundation
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MCHIP
MCJ-448132
10/01/94–09/30/99
Project Director:
Monica J. Schaberg, M.D., M.P.H.

PROBLEM: In 1992, the Rhode Island Department of Children, Youth and Families (DCYF) established a task force to assess the unmet health care needs of children placed by the department in substitute living arrangements (i.e., foster children). The task force determined that (1) 43 percent of foster children were "medically involved"; (2) 70 percent were placed in substitute living arrangements in a different community than their original home, breaking established relationships with a primary medical provider; (3) half of foster children caregivers had been refused physician appointments for their foster children; and (4) 40 percent of foster children used hospital emergency rooms for sick or urgent visits. As a consequence, these children were deprived of preventive health services, timely attention to acute conditions, and continuity of care, resulting in higher costs of short-term care and higher direct and indirect costs of complications of inadequate care (e.g., for preventable chronic conditions and disabilities). The task force also found that physicians were reluctant to accept foster children due to (1) low rates of medicaid reimbursement, (2) inadequate access to prior medical records, and (3) lack of access to a qualified source of medically indicated care coordination. However, the task force also found that these physicians would accept foster children on referral from DCYF, despite low rates of reimbursement, if the other problems could be resolved.

GOALS AND OBJECTIVES: The goal of this project is to plan and develop a permanent system of foster children's assessment, referral, and medically indicated care coordination that will assure all foster children of a "medical home" (i.e., a regular provider of pediatric primary care services in the child's community) that delivers (1) preventive, diagnostic, and therapeutic care; (2) appropriate referral (and followup) for special medical, developmental, mental health, and inpatient services; and (3) referral to a qualified provider of comprehensive care coordination for medically indicated social and support services. Specific objectives of the project are to:

1. Ensure that every child receives an initial health and developmental assessment;
2. Ensure that every child is referred to a medical home in his/her community, with results of the initial assessment and (where available) prior medical records; and
3. Ensure that primary care physicians are assisted in identifying a qualified community-based source of medically indicated care coordination.

METHODOLOGY: The Rhode Island Public Health Foundation is a nonprofit organization established by the Rhode Island Department of Health to facilitate development of public health interventions on behalf of the collaborating organizations that represent the community of solution for this problem: The Rhode Island Chapter of the American Academy of Pediatrics, DCYF, and the Rhode Island Department of Health. In year 1 the project will:

1. Develop an initial health and development assessment protocol for children newly in custody of DCYF;
2. Identify a panel of pediatric primary care providers willing to accept referrals from DCYF;
3. Identify qualified community-based providers of care coordination services;

4. Contract with community-based providers (e.g., visiting nurse associations) to provide assessment and referral services and medically indicated care coordination for a pilot test of the system for a sample of DCYF children;
5. Provide information to primary pediatric care providers statewide on care coordination providers in their communities;
6. Evaluate results of the pilot test to revise the system and estimate average costs per child served; and
7. Develop an incremental plan for statewide implementation and funding.

In years 2–5, the plan will be implemented and evaluated. A project advisory committee, with representatives from State agencies, foster parents, and the physician community, will guide the project, promote physician participation, participate in the evaluation, and promulgate and oversee implementation of the State plan.

EVALUATION: Medical and care coordination records of foster children will be reviewed to determine (1) level of improved access to primary care physicians; (2) timeliness, comprehensiveness, and continuity of care; and (3) reduction of preventable chronic conditions and hospitalizations. Participating physicians will be surveyed to determine effectiveness of the system in providing them with (1) adequate medical information on children at time of referral, and (2) access to community-based sources of care coordination. Foster parents and other caregivers will be surveyed to assess (1) access to care; and (2) timeliness, comprehensiveness, continuity, and cultural competence of care. The program as a whole will be assessed to determine (1) effectiveness in securing long-term participation of physicians, and (2) adequacy of long-term funding.

EXPERIENCE TO DATE: This project is a collaborative endeavor of the Rhode Island Chapter of the American Academy of Pediatrics; the State Departments of Health and Children, Youth and Families; and the Rhode Island Public Health Foundation. Organizational achievements included: (1) Adding the Rhode Island Chapter of the Academy of Family Practice to the collaborative, (2) broadening membership of the project's agency and physician steering committee to include significant representation of foster parents, and (3) hiring a health economist as a staff coordinator for the project, and as a negotiator for long-term funding arrangements with State agencies and third-party payers. Planning activities included revising priorities, objectives, and strategies for the project (e.g., to emphasize care coordination as the primary vehicle for achieving project goals; to actively involve parents in the care coordination process and train them to be care coordinators for their children; and to develop the care coordination system on a region-by-region basis rather than statewide from the start). Development activities included: (1) Design of a pilot project to identify demand for care coordination services, calculate costs of service delivery, and evaluate effectiveness in meeting patient needs and freeing physician time, and (2) preliminary discussions with personnel of the Department of Human Services concerning medicaid financing of medically indicated care coordination.

A 6-month contract has been signed with a regional visiting nurse association to provide care coordination services on a pilot basis to 100 foster children in 2 counties, and to collect demographic, medical, utilization, staff time, cost, and third-party reimbursement data for evaluation. Supplemental data will be collected through "satisfaction" surveys of participating physicians, foster parents, DCYF case workers, and others. As the pilot project moves forward, staff will: (1) Begin a series of formal discussions with State agencies on long-term financing for a statewide foster child care coordination system, and (2) develop detailed plans for going to scale.

Second Chance Club: A Family-Centered Intervention for Adolescent Mothers

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MCHIP
MCJ-458422
10/01/93–09/30/98
Project Director:
Janice Key, M.D.

PROBLEM: The pregnancy rate among adolescents is higher in the United States than any other industrialized country in the world; adolescents who already have one child have a particularly high rate of pregnancy. Infants born to adolescent mothers have many medical and developmental consequences, such as low birthweight, prematurity, developmental delays, and poor school performance. Adolescents who have a baby often drop out of school, have lower paying jobs, and have medical complications if they receive inadequate prenatal care. These medical and developmental risks are compounded if the mother has a second child while still an adolescent, close in timing to the first pregnancy. The Second Chance Club project will target adolescent mothers and their families by providing health education and counseling, both in their homes and in groups, in a culturally appropriate, multigenerational approach combined with medical services. The overall goal of this project is to reduce the rate of repeat adolescent pregnancy.

GOALS AND OBJECTIVES: The 5-year project has the following goals:

1. Increase effective use of contraception by:
   a. Increasing access to medical care and increasing medical funding; and
   b. Using skill-based education to improve decision making.
2. Increase effective discussion within the family about sexuality and family planning by:
   a. Increasing the parents' knowledge about these issues;
   b. Using skills-based education and counseling about communication; and
   c. Providing this education in a cultural context appropriate for the families being served.

METHODOLOGY: Approximately 80 to 100 parenting high school students and their families will participate. The project coordinator will serve as a case manager for all participants and will provide group counseling and education sessions. Eight peer educators (four adolescents and four parents) will be recruited from the participants and trained by the project coordinator and clinic staff. The peer educators will each visit 10 families in their homes monthly. They will develop and implement their own group and individual counseling sessions and materials based on existing materials. Medical care of the enrolled adolescents and medical insurance funding will be facilitated through affiliated school-based and adolescent clinics.

EVALUATION: Project activity is monitored through reports to the advisory board on a quarterly basis and an annual report. Ongoing monitoring includes completion of a signed informed consent prior to participation (signed by the student and parent or guardian); documentation of training of peer educators; documentation of each group meeting, attendance, and educational topic; and an annual structured interview of participants.

Intervention group data will be compared to that for two control groups:

1. Two hundred adolescents who delivered infants in other counties in South Carolina and matched for age, race, parity, and education will be tracked by MCH by using birth certificate data; and

2. Fifty-four matched volunteer controls who delivered infants in Charleston County will be contacted through a structured annual telephone interview.

EXPERIENCE TO DATE: The project is located in an urban high school as a part of a school-based clinic. The project has included weekly meetings at the school, a weekend retreat, participation in a tri-county health fair, representation at a State writing workshop, and a graduation ceremony. There have been no repeat pregnancies before high school graduation among active participants. This year the focus will change from multigenerational peer educators to education by nursing students.

Health Education Literacy Partnership (HELP)
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Dallas, TX 75215
(214) 670-8267

MCHIP
MCJ-488606
10/01/92–09/30/97
Project Director:
Alice I. Pita, M.D.

PROBLEM: Low literacy among low-income adolescent parents is a problem that affects all areas of their lives and the lives of their children. For the increasing number of clients who cannot read and who speak no English, access issues become even more complex. Literacy begins in early infancy with language development and the parents' positive reinforcement of their offspring's developmental milestone achievements. Many parents lack the skills and self-confidence to be their children's first teachers. This impacts the health care received and the ability to access resources effectively.

The Health Education Literacy Partnership (HELP) is a coalition of experienced professionals who want to make a significant difference in literacy and access to care. This project uses multilevel literacy guidance to parents and encourages them to complete their own education. A waiting room reading program functions in all clinic sites, with volunteers modeling reading for parents. Staff and volunteers provide free books and guidance about family literacy.

GOALS AND OBJECTIVES: The goals of HELP are to:

1. Increase access to health and social support services for high-risk mothers and their children;
2. Identify barriers to access for high-risk families;
3. Increase the literacy rate among high-risk mothers and the emergent literacy of their children; and
4. Increase awareness in the community and among pediatricians of the importance of emergent literacy and of the critical role of parents in this early educational process.

Ten specific goals will be achieved by 1997.

METHODOLOGY: Community service aides (CSAs) continue monthly contact with HELP clients. Because some client mothers go back to school, monthly in-home visits sometimes have not been possible. These clients may be seen in clinics when they bring their babies in for well-child checkups, or even at their schools. CSAs query clients about their children's health appointments, remind them to keep their own, and (by the fourth month of contact) administer the Rapid Emergent Assessment for Literacy in Medicine (REALM). They teach mothers how to play with their children to foster learning and emergent literacy. The volunteer readers for clinic waiting rooms read to the children, sometimes giving them books. By example and discussion, the volunteer readers teach parents about the importance of reading and how to share a book with their children. They may help parents to apply for a Dallas Public Library card. CSAs provide input on ways to fine-tune how best to carry out the HELP mission. Age-appropriate children are selected at random at public health clinics for the developmental testing done there. During clinic, nurses will administer the Early Language Milestones Scale (ELMS) and Attachment, Interaction, and Social Support (AIMS) to at least one client child 9 to 15 months old per day.

For parental reporting of literacy activities with their children, different approaches are being considered, including questionnaires and the Receptive-Expressive Emergent Language Scale (REEL).

EVALUATION: The High Risk Case Management data on the mother's progress toward educational goals, use of the health care system, REALM scores, and report of activities with her infant will be analyzed and correlated with her literacy level. Parent questionnaires describing in-home literacy activities will be collected in pediatric waiting rooms to assess increases in reading to children and increases in library use. Clients will have developmental language evaluations during regularly scheduled health appointments.

At monthly visits, CSAs monitor the mothers' response to HELP parent education materials, progress toward educational goals, use of medical services, and (for English-speaking mothers) literacy levels as determined by the REALM. Volunteer readers sign in where they are to read. The numbers of books distributed and received are documented in forms designed by and for HELP. The numbers of parent and pediatrician surveys are documented. The number of children seen in pediatric clinics is documented. The questionnaires dealing with in-home literacy activities will be documented.

EXPERIENCE TO DATE: Five specific program objectives dealing with obtaining baseline demographics and examining use of services have been reached. Five additional objectives deal with increasing levels of immunization (5 percent), use of Special Supplemental Nutrition Program for Women, Infants and Children (WIC) services (10 percent) and medicaid services (10 percent), reducing inappropriate emergency room use (20 percent), and overcoming other barriers to services (10 percent).

Results from last summer's survey of Dallas area pediatricians were encouraging. Eighty-four of the 143 pediatricians who responded routinely asked parents about reading to their children. Of those who responded, 59 percent said they talked to clients about reading, including 72 percent who discussed reading in early infancy and 24 percent who discussed reading in early childhood. A small number discussed reading prenatally. However, 41 percent did not talk with parents about reading at all.

Over 3,500 books were recycled from the Pediatric Society of Greater Dallas (private offices), city employees (public offices), bookstores (book drives, promotions, and donations) and selected PTAs. The Dallas Police Department storefront locations have agreed to be dropoff points for books, as have commercial recyclers not previously involved in book recycling.

Pediatric Clinic for Denton County
North Texas Community Clinics
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MCHIP
MCJ-488630
10/01/91–09/30/96
Project Director:
Melinda Mashburn, R.N.,
M.S.N., C.P.N.P.

PROBLEM: Denton County, TX, is a suburban and rural county situated in the northern portion of the Dallas-Fort Worth metroplex. It is one of the fastest growing counties in the United States, gaining almost 88,000 inhabitants during the last decade to reach a population of 273,000. In recent years this county lost its only public, nonprofit hospital, leaving medically indigent people with no source of health care other than the for-profit hospital emergency room.

Approximately 4,000 children in the county, ages 0–6 years, participate in the medicaid program; a similar number are eligible but not participating. No providers of primary care to children in the county accept medicaid, leaving them to be cared for at the local emergency room. These children do not get developmental assessments or health maintenance exams except for a few given at the Health Department. Immunizations are given at the Health Department, but the department has proven only marginally effective. Thousands of children have no access to even the most basic pediatric health care.

GOALS AND OBJECTIVES: The goals of this project are twofold:

1. Improve the health of children by improving access to care through the use of pediatric nurse practitioners; and
2. Demonstrate this approach as a reasonable, replicable method of delivering culturally sensitive, family-oriented, comprehensive pediatric care.

The program has several objectives:

1. Decrease unnecessary emergency room visits among this population;
2. Provide case management services;
3. Attain a high rate of immunizations among the pediatric population;
4. Compare the cost per patient visit with other providers' costs to demonstrate cost-effectiveness;
5. Serve 300 patients during year 1, increasing to 800 in year 2; and
6. Provide 70 percent of the patient visits with the nurse practitioners, without consultation or referral.

METHODOLOGY: Primary pediatric care will be provided by pediatric nurse practitioners in a nurse-managed setting. Well- and sick-child care—as well as immunizations, case management, and any necessary referrals—will be offered to low-income, medicaid-eligible children, ages 0–14 years, residing in Denton County. The effectiveness of this approach will be demonstrated by capturing objective data from internal and cooperating external resources to show both improvements in the overall health status of the population and problems within the health system itself.

EVALUATION: A data base collection system specifically designed for this project will collect pertinent demographic data on each patient upon entry into the clinic system, as well as at each clinic visit. Immunizations, diagnoses, interventions, referrals, and outcomes will be tracked and evaluated at least every 6 months to provide information to providers and the project director about the efficacy of this approach to care. Weekly staff meetings and monthly chart review and quality assurance activities will also provide needed information in this regard. An annual evaluation of progress made toward goals and objectives will be compiled and disseminated.

EXPERIENCE TO DATE: During year 3, enrollment in the pediatric clinic has again far surpassed the projected numbers, with over 4,000 active patients. A walk-in acute care clinic with extended hours has proven very effective and has been highly utilized, with over 1,200 sick visits per month. The pediatric nurse practitioners continue to provide comprehensive pediatric health care in over 94 percent of visits, without consultation or referral. Creative liaisons with pediatric specialists have been developed, linking pediatric clinic patients with an otolaryngologist, cardiologists, speech pathologists, and an audiologist who hold monthly onsite clinics. Staffing has increased to include a part-time pediatrician and more nursing staff. The pediatric clinic continues to be a sought-after site for nursing and nurse practitioner student preceptorships, due to the unique concept of nurse-managed health care.

PediPlace
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MCHIP
MCJ-488627
10/01/93–09/30/98
Project Director:
James Florez, B.S.

PROBLEM: Southern Denton County, TX, has a large, critically underserved pediatric population of children who are medically indigent, medicaid eligible, uninsured, or insured but denied access to health care because their families cannot afford out-of-pocket medical expenses. Medical services are fragmented due to a lack of pediatric providers. There are only six pediatricians to serve a pediatric population of more than 35,000 children. Although there are more than 1,200 medicaid-eligible families in the target population, no pediatricians in the area accept medicaid patients. These children do not receive developmental assessments except for the few given at the Health Department. Denton County has no public or nonprofit hospital to provide indigent care, leaving this population to be cared for at the local hospital emergency room. Thousands of children in this area have no access to generally accepted pediatric health care.

GOALS AND OBJECTIVES: The goals of PediPlace are to:

1. Remove barriers to health care by providing a medical home to the uninsured, underinsured (i.e., unable to meet deductibles or copayments), and medicaid-eligible pediatric population of southern Denton County. PediPlace will offer preventive screening and diagnosis as well as immunizations (in cooperation with other area immunization programs), and it will emphasize continuity of care for acute/chronic medical problems.
2. Deliver information and care with the expectation of patient and family responsibility and accountability. PediPlace will seek to empower parents with information and skills in anticipation of their assumption of responsibility for the child's home health management.

METHODOLOGY: The goal of improved access to health care will be accomplished by providing a pediatric center for sick-child and well-child care to be staffed by pediatric nurse practitioners. Extended hours will improve access for parents who work full time. Continuity of care will be achieved through cooperation with local agencies and organizations also serving the target population in order to prevent gaps in care and overlap of efforts and resources. Local volunteer pediatricians will provide call support for patients who have more acute problems or who need inpatient or emergency room care.

EVALUATION: The effectiveness of this approach will be measured by internal data and by external sources. The efficacy of PediPlace will be measured by the reduction of emergency room visits for nonemergency situations, an increase in immunizations (measured by PediPlace), an increase in the number of children enrolled in medicaid, and an increase in attendance for followup care and well-baby/well-child visits.

EXPERIENCE TO DATE: Construction of PediPlace was completed in mid-November 1994 and was staffed and equipped for its first day of operation in December 1994. As of June 1, 1995, PediPlace had registered 1,078 patients and provided more than 2,400 patient visits. A case management and human services referral program has been developed and partially implemented. PediPlace has also established partnerships with the physician assistants program of the University of Texas Southwest Medical School to serve as a clinical rotation site for students. Similar partnerships have been formed with nursing programs at the University of North Texas, Texas Woman's University, University of Texas at Arlington, and North Texas Community College. A Denton

County Health Department WIC worker began providing WIC screening and registration at PediPlace in June 1994.

Teen Clinic
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MCHIP
MCJ-488615
10/01/92–09/30/97
Project Director:
Joan Dentler, M.Ed.

PROBLEM: The Brownsville Community Health Center (BCHC) established the Teen Clinic in response to the many needs of its adolescent patient population. High-risk activities of adolescents identified as prevalent in the area include substance abuse, poor academic performance, and risky sexual activities. These activities have negative consequences, as reflected by the city's high adolescent pregnancy and dropout rates. Such problems are compounded by widespread poverty. Prior to the creation of the clinic, services for adolescents in the community were focused on single behaviors; coordination of care was minimal, and there were no health care providers explicitly interested in and committed to adolescents.

GOALS AND OBJECTIVES: The goal of the Teen Clinic is to reduce the adolescent pregnancy and school dropout rates in its patient population. In order to measure progress in these areas, process objectives have been established involving (1) delivery of comprehensive health care, (2) adolescent counseling, (3) an increase in the number of referrals from underserved schools, (4) an increase in the number of clients who apply and qualify for medicaid, and (5) improvements in adolescent knowledge about family planning. The clinic has established three intermediate outcome objectives:

1. Prevent 50 percent of sexually active female patients from experiencing a pregnancy over a period of 1 year or until high school graduation;
2. Prevent 75 percent of adolescent parents from experiencing repeat pregnancy over a period of 2 years or until high school graduation; and
3. Maintain the enrollment of 50 percent of patients identified with poor academic performance in school for 1 additional year or in an alternative educational program.

METHODOLOGY: The Teen Clinic offers comprehensive health care that addresses the special needs of adolescents, including medical care, health education, and counseling. Indepth risk assessments are completed on each adolescent and interventions are planned accordingly. The clinic has been held two afternoons each week and is currently staffed by a nurse practitioner, two physician assistants, and a social worker. For the upcoming 1994–95 school year, as a result of our project, two full-time teams will be stationed to service four school sites.

EVALUATION: In order to evaluate the intermediate outcome objectives, a periodic interview (every 6 months) will be undertaken with each adolescent. This structured interview will record not only the number of pregnancies and number of dropouts but also the adolescents' evaluations of how the Teen Clinic has affected their lives. It will be conducted by the social worker at the end of the visit. The project will also continue to monitor and evaluate the patient population risk statistics.

The clinic monitors the health status of patients and clinic activities in several ways. Each patient completes a risk assessment survey at the first visit. Based on the responses, a risk score is assigned to the patient over a range of categories. In addition, a patient information form is completed by the provider at each visit; the form enables tracking of demographics, diagnosis, services, referral, and payment source. The data from these two forms are organized in an electronic data base. In addition, information on the status of enrollment in medicaid will be maintained to assist the clerk in maximizing enrollment. The clinic staff will hold monthly case review meetings to monitor and improve coordination of services.

EXPERIENCE TO DATE: During this period, numerous personnel were added to the staff, including a project director, a master social worker, and a family nurse practitioner. Clinic sites increased to five separate sites, including a high school and elementary schools. A clinic continues to be held one afternoon each week at the Brownsville Community Health Center for students who do not attend the catchment area schools or who need ancillary services that cannot be offered at the school-based clinics. The School Based Health Center received a Health Promotion Excellence Award from the Texas Department of Health in May; the project was nominated by the Brownsville Independent School District, which should be an indication of the school district's attitute toward the project.

Comprehensive Health Investment Project of Abingdon
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MCHIP
MCJ-518008
10/01/95–09/30/2000
Project Director:
Robert G. Goldsmith, M.A.

PROBLEM: Low-income families and pregnant women in the Washington County and Bristol, VA, service area experience barriers to access to health care. These barriers include unemployment, high poverty rates, lack of health care insurance coverage, personal and cultural factors affecting a woman's attitude towards pregnancy and prenatal care, physician availability, physician willingness to provide services to low-income families and pregnant women, and a lack of transportation. These barriers contribute to and increase prenatal and child health status problems such as low immunization rates, low numbers of well-child and prenatal visits, high infant mortality rates, and low birthweight rates.

GOALS AND OBJECTIVES: The program goals are to

1. Provide an additional 60 children, ages 0 to 6, and 20 pregnant women in Washington County and Bristol, VA, access to a comprehensive, coordinated, community-based network of health and family support services;
2. Improve the health status of these low-income pregnant women and children by providing health and social case management services resulting in a comprehensive health care and family asistance plan for each CHIP participant;
3. Promote parental involvement as an integral part of each child's health and welfare, development, and education; and
4. Assist families in moving towards self-sufficiency and empowerment.

Objectives are to:

1. Sustain and increase the multidisciplinary network of community physicians who agree to provide health care services to the existing and expanded service area on an ongoing basis;
2. Increase appointment compliance of CHIP families with private and public health care providers to at least 90 percent;
3. Ensure that 100 percent of CHIP children receive primary care services from the same medical provider (their medical home);
4. Ensure that 100 percent of prenatal CHIP parents receive regular prenatal checkups;
5. Ensure that 90 percent of CHIP children receive well-child visits;
6. Increase each family's ability to communicate its needs to health care providers;
7. Reduce unnecessary emergency room usage by 30 percent;
8. Ensure that each child has annual dental checkups and specialized dental care as needed;
9. Provide early developmental screening to 100 percent of CHIP children for the detection of developmental delays;
10. Increase each family's understanding of and ability to appropriately use existing community resources;
11. Improve the immunization status of CHIP children ages 2 and under to 98 percent;

12. Reduce the incidence of unintentional deaths, serious injuries, and preventable hospitalization of CHIP children by 15 percent; and
13. Ensure that at least 25 percent of CHIP families participate in family-centered parent involvement activities on an ongoing basis throughout the year.

METHODOLOGY: The program will recruit, hire, and train two paraprofessional home visitors and one public health nurse who will provide medical case management and family support services to newly enrolled participants. In addition to maintaining existing relationships with current CHIP providers, at least three additional physicians and one dentist in the service area will be recruited as CHIP providers. The CHIP team will maximize the use of existing community resources, decrease fragmentation of health care services, and reduce duplication of services through ongoing communication and coordination with providers and community agencies and programs also serving low-income children and pregnant women. Each family, along with the CHIP team, will assess their needs—including transportation, health, mental health, and social needs—using a family needs and health care assessment instrument within 60 days of enrollment. From this needs assessment, a family assistance plan and health care plan will be developed to direct the medical and social case management of each family. Through interactive home visits with both the home visitor and the public health nurse, parents will receive education on the importance of regular health care for children and regular prenatal care, early and positive childhood development, immunizations, home safety, childhood illnesses and care of sick children, well-child care, medical emergencies, dental and personal hygiene, safe use of prescription and nonprescription medication, nutrition, access of community resources, and positive parenting skills. Home safety assessments will be conducted in each home to reduce unintentional injury potential and to teach parents how to make their homes safe.

EVALUATION: The program has an evaluation process in place through the University of Alabama, Birmingham. A three-phase, indepth program evaluation of CHIP is being conducted. Phase I developed a data system that collects descriptive information on all enrolled families; Phase II developed a process evaluation of CHIP; and Phase III will perform a prospective study of all CHIP sites, which will include child health and family self-sufficiency outcomes. Other evaluation tools will include quarterly progress reports, quarterly staff case reviews, monthly staff meetings, annual staff appraisals and development needs assessments, and annual parent and physician satisfaction surveys that provide assessments of the project and recommendations for change.

Teen Pregnancy Service:
Adolescent Primary Care
Medical College of Wisconsin
Teen Pregnancy Service
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MCHIP
MCJ-558521
10/01/93–09/30/98
Project Director:
Aileen Fiorita, B.A.

PROBLEM: The Teen Pregnancy Service of Milwaukee seeks to expand services to the high-risk population of adolescents, children, and infants it currently serves. The population initially targeted for services through this project consists of pregnant and parenting Teen Pregnancy Service clients ages 13–19. This high-risk population, though culturally diverse, is predominantly African American; 95 percent are of low-income status. During the second year of the project, the target population will be extended to include clients enrolled in our primary prevention program. This group comprises nonparenting males and females, ages 10–18, who are assessed as being at high risk for becoming adolescent parents. As risk factors tend to cluster rather than occur in isolation, both populations exhibit a significant number of interrelated risk characteristics such as poor academic achievement, substance abuse, delinquency, poor parent-child relationships, and low self-esteem, in addition to the potential health risk associated with early parenting.

Adolescents generally tend to underutilize the health care system. Reasons given for this lack of use are inaccessibility, lack of confidentiality, unaffordability, and lack of perceived need for health care. In Wisconsin, 53,052 adolescents (ages 15–20) were eligible for a HealthCheck screen but only 3,017 (5.7 percent) had these screens. Approximately 50 percent of girls ages 15–19 have had intercourse. Of sexually active girls, more than half report inconsistent use of contraception. Rates of sexually transmitted diseases (STDs) among adolescents are rising, with syphilis at the highest level in 40 years. AIDS is now the seventh leading cause of death among adolescents and young adults 15–24 years old. Adolescent pregnancy rates are not declining. Because adolescents tend to participate in many experimental and risk-taking behaviors that lead to negative health outcomes, lack of preventive and primary health care may have costly societal and economic repercussions in the form of premature pregnancy and parenting, increase in STD/HIV infection, diminished potential for self-sufficiency, lost productivity, and academic or vocational failure. The expansion of services seeks to fill critical gaps in the accessibility of care, including coordination of case management services to address pervasive issues associated with adolescents and early parenting and comprehensive primary health care services designed to meet the needs of this population.

GOALS AND OBJECTIVES: The Adolescent Primary Care model will combine the effectiveness of care coordination/case management with the availability and accessibility of comprehensive primary health care in a community and familiar environment. The overall goal is to provide effective comprehensive primary health care to adolescents in a cost-effective and culturally relevant manner. Comprehensive health care in the context of this project builds upon prenatal services currently provided and an acute awareness of the special needs of this population to include not only medical but also social and psychological interventions.

Special consideration will be given to the goal of increasing community involvement and cultural sensitivity in the project design because of the critical effect of the community's makeup and problems on this population.

METHODOLOGY: Pediatric primary care teams at the Teen Pregnancy Service include a nurse practitioner, a pediatrician, and a social worker. A nutritionist is available for consultation. Services with a preventive and educational focus to be provided by the primary care team include assessment of nutritional status, general physical and mental health, oral health, sexuality, risk-taking behavior, perinatal status, and other issues related to growth and development. Also to be provided is family (postnatal) care coordination that will utilize the concepts of the Parent Support Program, whose fundamental goals are to improve the parenting skills, daily life and self-advocacy skills, and support systems of adolescent parents at risk for child abuse and neglect.

Community agencies will be contacted to (1) join an advisory board for program development, (2) develop and implement community outreach efforts, and (3) collocate services at the Teen Pregnancy Service.

EVALUATION: The number of clinic visits will be monitored and tracked to ensure that Teen Pregnancy Service clients have the opportunity to receive and are receiving comprehensive primary health care, family (postnatal) care coordination, and services from the Parent Support Program. Also, baseline data on the incidence of repeat pregnancy rate will be collected and compared to the same measures obtained after the new initiatives are implemented. Program recommendations from the advisory board and the implementation of the outreach workplan will be monitored.

EXPERIENCE TO DATE: Primary care and care coordination services are being provided to adolescents. All clients have the opportunity to participate in one or more parent education and support programs. These programs are held onsite or in community settings in order to be accessible to the teen parent population. The agency will continue to collaborate with community organizations in strengthening support and educational services. Establishment of the advisory board has been slower than anticipated. Additional funding is being sought from State and local sources to assist in this effort.

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MCHB
Maternal and Child Health Bureau

HRSA
Health Resources and
Services Administration

NCE
MCH
National Center for Education
in Maternal and Child Health

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